

Report of the Governor's Commission on Nursing Homes

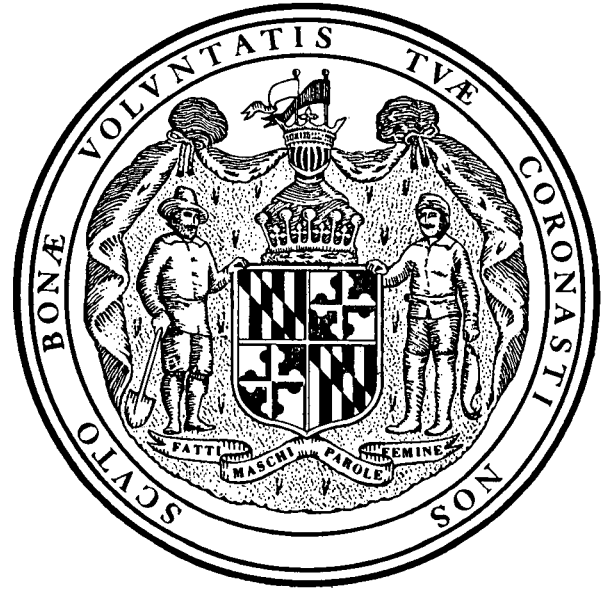


The Government, the Community, the Institutions

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Report of the Governor's Commission on Nursing Homes





MARVIN MANDEL
GOVERNOR

GOVERNOR'S COMMISSION TO STUDY
PROBLEMS IN NURSING HOMES
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July 1973

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CHAIRMAN

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383-4956

Honorable Marvin Mandel
Governor of Maryland
State House
Annapolis, Maryland

Dear Governor Mandel:

This Commission is pleased to submit its final report which concludes the eighteen-month study initiated at your request.

On behalf of the Commission members and myself, I wish to express our appreciation at being able to serve you and the people of Maryland in this area of vital importance.

While we lament the causes which brought about the Commission, it is our hope that the recommendations contained in the final report will result in long-range, comprehensive solutions to the problems which precipitated the Salmonella crisis.

Sincerely,

Joseph A. Sellinger S.J.
Joseph A. Sellinger, S. J.



MARVIN MANDEL
GOVERNOR

EXECUTIVE DEPARTMENT

ANNAPOLIS, MARYLAND 21404

July 1973

My fellow citizens:

As many of you know, three years ago this summer thirty-six elderly residents of Maryland lost their lives as the result of an outbreak of Salmonellosis in a Baltimore City nursing home.

In response to this tragedy I ordered the creation of a seven-member commission to investigate nursing homes and other aspects of long-term care. This Commission, chaired by the Very Rev. Joseph A. Sellinger, S.J., has now completed its work and submitted a final report which includes major legislative and administrative recommendations.

I know I can speak for the 300,000+ senior citizens in Maryland, professionals in the field, and the general public, in expressing my gratitude for the dedicated work of this Commission.

I pledge my continued support to ensure that Maryland's older adults receive the services they rightfully deserve. My office, in close cooperation with the State Legislature, will carefully review and analyze the Commission's recommendations in the ensuing months.

Sincerely

Governor's Commission on Nursing Homes

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This report was edited by Robert A. Potter, who served as editorial consultant to the Commission on Nursing Homes.

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Report of the Governor's Commission on Nursing Homes

A:

A Report on the Problems of the Aged and Long-Term Care in Maryland

Three years ago, 36 old people lost their lives in a tragic incident in a Baltimore nursing home. It is critical to this report that we restate a major finding of the board of inquiry that investigated the Gould Convalesarium incident.

The investigation indicates individual failures by physicians, by those who run nursing homes, by state and city health officials, by state and national government. The evidence presented clearly shows that we have allowed these homes to operate in a bewildering tangle of bureaucratic regulations and inadequate laws, where state agency overlaps city agency, where ambiguous lines of authority and the absence of clearly delineated responsibilities create confusion and carelessness, and where lack of adequate supervision potentially endangers the life of every patient in every nursing home.

The Governor's Commission on Nursing Homes believes that the inability or unwillingness of state agencies and long term care facilities to deal in a concerted and integrated manner with problems of the aged, continues to be the major problem of our old people who require long-term care and the major obstacle to the development for our aged of meaningful alternatives to institutionalization.

During this Commission's 18-month life, it has been heard time and time again from state and local officials, voluntary agencies, professionals in gerontology and from private citizens, that lack of strong leadership in the health and social-service arenas, the absence of a strong operating and advocate agency for the aged and the refusal by many nursing homes to assume responsibility for patient care and support, has resulted in fragmented, under-financed, badly supervised and haphazard programs for the aged in Maryland.

During public meetings this Commission was told repeatedly that the major problems facing older people are lack of money, and lack of concern by children for their aged parents.

In the view of this Commission, these protestations, while undeniably real problems, are an attempt by officials in the state agencies to deny or

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abdicate responsibility for programs, policies and—above all—people for whom they are responsible.

Within all the major departments which have programs dealing with the aged there are dedicated, concerned, and talented public servants. There is, however, no leadership at the top. Far too often what appears to be a policy of crisis reaction can be clearly seen, most notably in the State Department of Health and Mental Hygiene.

- It was not until the press exposed the misuse of patient's money by some large nursing homes that the State Department of Health and Mental Hygiene was willing to act. This problem did not suddenly appear on the scene, but rather, had been ignored by those in positions of leadership.
- Long before the naming of this Commission, health professionals, social workers and nurses, as well as the general public had been aware of the difficulty of locating appropriate beds for patients coming to nursing homes from acute hospitals or their own homes. If a central bed registry does come about, it will be as a result of community volunteers, organized by this Commission, and not from the initiative of the Department of Health and Mental Hygiene.
- There continues to be a problem concerning the way in which a patient's personal laundry is paid for in a nursing home. The State Department of Employment and Social Services began a policy whereby laundry could be paid for from the personal allowances of patients. There was, however, no limit set on the amount. As a result, some facilities are charging as much as \$20 a month, which leaves little money for the patient to use for personal items.

We raise these issues to demonstrate the lack of clear, authoritative program planning within the state bureaucracy. It is apparent that the generic/non-categorical approach to health and welfare problems of the aged has resulted in a proliferation of programs throughout a variety of State departments. This piecemeal philosophy has resulted in either an abdication of responsibility or an assertion that all policies and programs are coordinated and working well.

To further demonstrate that indeed all is not well, one need only analyze the area of domiciliary/community-based care as an alternative to institutionalization. We have a Geriatric Screening and Evaluation Service which, under severe financial and personnel constraints, is doing a fine job of preventing unnecessary and inappropriate institutionalization, and a Division of Chronic Disease and Aging seeking to develop effective community services. On the other hand, however, elderly persons are being released from state hospitals into communities without resources to help them.

Little joint planning has taken place between the Department of Health and Mental Hygiene and the Social Services Administration to develop

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appropriate methods for domiciliary care. When called upon (again due to the interest of the press) to investigate complaints about University House in Baltimore, there was no mention made of whether this was an appropriate site, mix of patients, facility size, or level of care, for use as an alternative to nursing homes.

OFFICE ON AGING

- Based on the above examples and other problems to be discussed, the Commission makes its major recommendation: The creation of an Office on Aging.

The Office on Aging should have the authority, responsibility and resources to carry out the following assignments:

- (1) Carry out Titles III and VII of the Older Americans Act as amended, which includes Title III (Grants for Community Programs on Aging); and Title VII (Nutrition Programs for the Elderly).
- (2) Direct future programs established through amendments to the Older Americans Act.
- (3) Establish and operate a retirement information and referral service for the aged. This service will provide information, counseling, linkages and follow-up in the areas of health, social services, pre-retirement and retirement counseling, recreation, education, housing, nutrition, and legal services.
- (4) Review and make recommendations on state plans and programs which could have an impact on the elderly. Such state plans and programs would be submitted to the Office on Aging prior to their official implementation.
- (5) Develop funding for statewide geriatric screening and evaluation centers, which would be linked to health and social service facilities serving specific areas.
- (6) Evaluate, analyze, and make policy recommendations to the Governor, Legislature, and state agencies in the long-term-care area, including social, medical, nursing, and recreational services.
- (7) Assist in the development of alternative choices for the aged through the planning and delivery of community and home-based services and innovative programs for institutionally based services.
- (8) Prepare and submit a budget.
- (9) Conduct public hearings, with power to subpoena, examine witnesses under oath or affirmation, and require the production of any books, records, documents or other evidence.

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Such an agency, although it would be a major upgrading of the existing State Commission on Aging, will not be a panacea. Rather, it would be a base upon which other program and policy recommendations could be built. The Office on Aging, with a Senior Citizens Advocacy Commission, and Interdepartmental Committee on Aging, would be the principal agency of state government and a powerful, visible agency under which programs for Maryland's older adults could become effective and efficient.

While the majority of the issues with which this Commission concerned itself impinged upon the state government, there were individual policies which had to do only with long-term-care institutions. In the problem areas discussed in this report, the lack of authoritative, firm, and rational policy-making is clearly evident.

OMBUDSMAN

Most of the money paid to long-term-care facilities in Maryland, as in other states, is public money. The majority of patients residing in nursing homes receive public assistance. The vast majority of patients entering long-term-care facilities do not return to the community. It is tragic that there is no public advocate for them, in view of the fact that the public pays the bill.

Although public agencies such as Legal Aid, and many voluntary groups, have tried with meager resources to be helpful, patients in nursing homes are still without a single source to represent them. While the Division of Licensing and Enforcement of the State Department of Health and Mental Hygiene has been significantly improved since the deaths at the Gould Convalesarium, it still seems unwilling to become an advocate for individual patient needs and rights.

The following case demonstrates the problems nursing-home patients can have. It is only one of many similar cases reported to this Commission during the past 18 months.

In September 1972 a nursing-home resident received a back payment check from Social Security for \$1,954.50. He was not permitted by the nursing home, however, to see the check's amount and assumed he was signing his regular monthly check for \$130. The Department of Employment and Social Services accidentally discovered the true amount of the check and informed the patient. When the nursing home refused to turn the funds over to him, he got legal counsel. The nursing-home chain then offered to give him \$1,300 of his funds, which was refused. The second offer went up to \$1,457, which he also refused. The nursing home maintained that it was necessary to retain some of the patient's personal funds because the State Department of Health and Mental Hygiene was always behind in its payments to the home. In 1973 his legal counsel settled for a refund of \$1,869. There is still some question about the remaining \$83.

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Given the great amounts of public monies going to nursing homes, and given the relative "powerlessness" of nursing home patients, the Commission on Nursing Homes recommends that a non-profit *ombudsman* be established to:

- Serve as a patient advocate for persons in long-term care facilities.
- Provide concise, up-to-date information regarding federal, state, and local programs and procedures.

The Commission urges that the ombudsman be established as a non-profit corporation outside the state bureaucracy. It should, however, have close ties to the Office on Aging to ensure that the problems of the aged are being given fair consideration.

SOCIAL SERVICES

Few examples of public policy are more misguided than the legislation which removed the obligation of states to provide social services in skilled nursing homes. Prior to this decision by the federal government, the states were *required* to furnish social workers to nursing homes. Perhaps the most glaring deficiency found in Maryland nursing homes is the lack of social-work services. Far too often the following situations were discovered: A social-work consultant was on the staff, but was either rarely utilized or used inappropriately; there was a complete lack of understanding as to what constitutes social services; and the facilities saw social workers as a potential threat to the facility's operation.

It is important to understand the situations in which nursing home patients find themselves in order to demonstrate the critical need for social services in all long-term care facilities.

The use of the terms *skilled nursing*, *extended* or *long-term care*, assumes that most of the residents in nursing homes have a debilitating or disabling condition that severely limits the amount of energy they can devote to caring for themselves. In addition to their health problems, the residents often suffer from a psychological-social malady that is perhaps even more debilitating than physical illness: *institutionalization*. The nursing home, according to a widely held and altogether accurate perception, is also seen as a one-way trip.

Once settled into a long-term-care facility, the institutionalization process brings about feelings of anomie, abandonment, loneliness, uselessness, impotency, and a variety of other behavior manifestations, all contributing to the need for social services. The need is equally critical for residents who should not be in the facility at all.

The families of patients are not immune from this lack of authority or ability to influence decisions. For many, the fear of retribution upon the relative in the nursing home prohibits complaints. For others an ignorance of

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the procedures necessary to navigate the complex system with which they are dealing effectively closes all paths which might solve the problem.

The following cases are examples of the need for *professional* social services in all nursing homes and other facilities providing long-term care.

Example: Mrs. H., an 89-year-old widow with no children, immigrated in 1906 with her husband, who died a short time later. Following his death, she supported herself as a domestic. A fiercely independent woman, despite poor health, she insisted on living alone until she was well into her 80's. She was admitted to a nursing home in 1969 after fracturing her hip, but was able to move about. Since breaking her hip again in 1971 she has not been able to walk by herself, however, and needs help moving just from her bed to a chair. She participates in no activities and has no interests; she is socially isolated and has a poor self-image. Her entire day is spent in a chair in her room where she does not even have television. Her niece never visits and she has no significant relationship with other patients; her only contacts are the nursing-home staff.

Her nursing home has no regular activities and no activities director on the staff. There is no room designated for activities except a lounge area, which is used as a sitting, television, and dining room.

When an occasional activity is scheduled, Mrs. H. is not included, possibly because she is difficult to move or because the staff interprets her lack of motivation and depression as lack of need for activities. No volunteer groups are involved on a regular basis in the nursing home so there is little possibility of a visitor for her. The staff has never attempted to help her develop a relationship with other patients.

The staff reinforces Mrs. H's feelings of worthlessness. They do not speak to her and appear not to understand her feelings. For example, her commode chair is in a four-bed room in full view of a busy hallway. The home has no social worker and the nursing staff has neither time nor experience to counsel Mrs. H. about her depression and feelings of worthlessness; the only counseling available has been through a state intermediate care social worker in a program that was ended in April 1973.

Example: Mrs. S., 80, a widow for more than 30 years, is the mother of two daughters, who are married and living out of the state, and of one son who lives near the nursing home.

An alert, intelligent woman, Mrs. S. expresses herself well. She traveled extensively with her husband, and after his death, she supported herself with several jobs, most recently as a nurse-companion. She has a number of interests and good general knowledge.

Her relationships with her children and their families have been congenial. She receives frequent letters from her daughters and one grandchild, but the distance involved means she sees them only once or twice a year. The son

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visits every week. A close friend, who visited once or twice a week and handled her personal affairs, died recently.

Mrs. S. came to the nursing home 18 months ago following her release from a hospital, where she had been treated for a fractured right ankle. She has a history of frequent falls with fractures. She also has cataracts. Physical therapy has not been available. She is able to walk only short distances, even with the use of a walker.

She is depressed about her situation and needs counseling. She needs help to focus on her strengths rather than weaknesses. Because of her depression, she is not motivated to involve herself with others or to take advantage of activities. She spends more and more time in bed as a result of how she feels about herself and how she believes the home feels.

She shares her room with a very senile patient who is at times quite agitated. Mrs. S. finds it difficult to relax and claims she finds sleep almost impossible. The pairing up of patients in this fashion is not an uncommon practice.

The home's lack of understanding of the patient's need for dignity, sense of worth, and usefulness permits the staff to act in ways which deny these needs. Laundry is carelessly handled—Mrs. S. sometimes must wear clothing of deceased patients—depriving her of a sense of individuality. Failure on the part of the staff to recognize those things which are important to Mrs. S. deprive her of her sense of worth: For example, an article of clothing lost has been upsetting for Mrs. S. as it was a gift from her now deceased friend. The discontinuance of physical therapy is interpreted by Mrs. S. as indifference by the home and she has lost hope.

The Commission believes that social-work services (working closely with patients and families to resolve problems associated with institutionalization) are of vital importance and must be upgraded; therefore, the following recommendations:

- Continue the requirement that as a condition of licensure there be social services in every nursing home, despite federal guidelines encouraging discontinuance;
- Set guidelines for proper and worthwhile social services and provide assistance in their development and organization;
- Develop in-service training programs for staff and include as part of the curriculum, discussions on the emotional, social, and psychological needs of patients;
- Require that all social services in long-term care facilities be provided by, or supervised by, individuals holding masters degrees in social work.

LEVELS OF CARE

In few areas is there more confusion among federal, state, and local health officials than in the area of *levels of care*. It is quite evident that the current

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system and the accompanying payment mechanisms operate from a *pathological* model; that is we pay for illness rather than for health.

This system begins to operate with a decision about the level of care appropriate to the patient's needs. Once it is decided that a patient is eligible for discharge from a hospital the system takes over. (It should be made clear that patients receiving public assistance are being discussed not private patients for whom the system is somewhat more rational).

A form SHD-29, for determination of level of care, is filled out at the hospital. Although a medical form that must be signed by a physician, it is often completed by a nurse or social worker, who often does a better job than a physician. Doctors tend to highlight issues and ignore other problems that can result in a nursing home refusing to accept the patient.

The form is then sent to the local health department, where nurses decide the level of care, either skilled or intermediate. (Chronic care can be approved only by the State Department of Health and Mental Hygiene). Once the level has been decided, the form goes to the local department of social services for approval of financial eligibility. Upon completion of these paper transactions, the hospital is notified that the patient is eligible for discharge.

Meanwhile, "back at the hospital" there are crushing pressures to move the patient out if public assistance has been exhausted. If the patient is ill and requires extensive and expensive nursing care, but falls short of the chronic disease classification, critical problems immediately arise. Skilled nursing homes, in most cases, refuse to take patients who will require daily care costing more than the \$18.00 limit of Medicaid. Thus, this patient, who through no fault of his own falls between the level-of-care "cracks", either languishes in the hospital at enormous cost to the state or returns home to die.

For the patient classified skilled and for whom a skilled bed is located, the problem of the pathological orientation is far from over. If he or she benefits from the care provided and the level of nursing care required drops to the intermediate level, more often than not the patient is forced to either move to an intermediate wing within the facility (thus having to leave the room and roommate with whom he is familiar) or in many cases, since the skilled facility may not have intermediate beds, to a home offering intermediate care. (Often this second facility may be on the other side of town, far from friends and relatives).

This deplorable situation is not limited to those undergoing permanent changes in level-of-care status. If a patient is on medical-assistance and the family wishes to bring him home for a brief period—such as Christmas—the nursing home will not guarantee the bed. Thus, it says to the patient: "Stay ill and we will care for you, get better and risk losing your bed." The following cases exemplify the situation.

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Example: Mrs. S., 91, lived with her 45-year-old retarded, granddaughter. Mrs. S. had cared for the granddaughter until her own condition deteriorated to a point where she was unable to provide necessary care and supervision. Mrs. S., upon discovery of her age, diabetic condition, and minor senility, was classified as requiring skilled nursing care. The granddaughter was certified as requiring intermediate A care, forcing them to be separated. The doctor on the case asserted that separation could hasten the premature death of either party, given their close dependency.

It was only after crisis intervention on the part of a local health agency that Mrs. S. was recertified as intermediate A and enabled to live in a nursing home with her granddaughter.

Example: Mrs. M., a 70-year-old diabetic, entered a skilled nursing home in July 1972, because of a heart ailment that needed daily monitoring. She is ambulatory and able to care for herself, as well as participate in nursing-home activities. The home encourages her to stay because she costs much less in staff time than the standard reimbursement of \$18 a day, as well as being an easy and pleasant person. In contrast, Mr. N., a recent stroke victim needing tube feeding, catheter care, and extensive general nursing care, was admitted reluctantly after pressure from a hospital social worker who was having difficulty finding him a bed. After a week, Mr. N. needed oxygen, which is not covered by Medicaid, so the home sent him to the emergency room of the hospital and refused to take him back. He had cost the home far more in staff time and supplies than Mrs. M. and was not a *profitable* patient.

The Governor's Commission believes very strongly that such situations are a direct result of federal policies, which do not provide incentive for homes to move patients toward health and discharge. Indeed, we pay to keep beds filled at the highest level of care, which, of course, means more money for the nursing home.

In an attempt to alter this system of reimbursement for care, the Governor's Commission recommends legislation in the following direction:

- Realign the levels of care in Maryland. Include in the realignment those patients presently classified as chronic, skilled, intermediate A and intermediate B. One possible approach is to do away with levels of care and instead evaluate every individual entering a long-term-care facility in the context of his unique problems and potential, and incorporate into the evaluation the individual goal by which progress can be measured.
- Realign the reimbursement rates for nursing-home care. The present rates do not account for the variance in amounts of nursing care needed by patients within a similar classification. One possible approach is to adopt patient "reasonable cost" reimbursement as is presently done in hospitals. This would be the most appropriate method if levels of care are abandoned.
- Increase the required minimum nursing care. Require on-floor nursing of 2.5 hours per patient per day. At the same time, allow flexibility in the minimum

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staffing requirements by basing requirements on the number of maximum care and intermediate care patients in the home. For example, a particular home taking 50 percent maximum-care skilled patients would be required to have a larger nursing staff and would be reimbursed higher than a home that had only 20 percent maximum-care patients. This would facilitate placing the maximum-care patient and help ensure that he received the quality care needed.

MENTAL HEALTH AND AGING

It is disheartening to report on an issue which, for so long, has been recognized as a blot upon the long-term-care field. Although great progress has been made in understanding the mental health of old people, some fundamental changes must yet be made.

The Geriatric Screening and Evaluation Service represents a major effort to inhibit the dumping of patients in the geriatric wards of state mental hospitals. Until such services are expanded to all areas of the state, however, patients will continue to wind up in mental hospitals as a result of the use of such facilities as a first rather than last resort.

In addition to the problem of inhibiting inappropriate institutionalization, the state must face the continuing problem of how to handle the elderly individual being discharged from the hospital into the community.

While one cannot disagree with a policy to "empty" the state mental hospitals of elderly patients not requiring such care, there must be appropriate facilities within the community to which they can be sent. To place these individuals in our poorer nursing homes, in large, undifferentiated, downtown domiciliary homes, or into apartments without services, may not be improving their situation and may result in premature death or return to the mental hospital.

The following cases are illustrative of the problems surrounding mental health and the aged.

Example: In the fall of 1972 Mrs. O., 73, was found wandering on the street. After failing, through repeated attempts, to have her linked up with an appropriate Geriatric Screening Service, her son was forced to leave his own hospital bed and take her to the nearby state mental hospital. Although the doctor on the case asserted that home-based services could enable her to remain at home, such a constellation of services was not available, Mrs. O. was thus admitted to the mental hospital and placed in the geriatric ward. She suffered a fatal heart attack soon after admission.

Example: Mrs. A., a 70-year-old patient in a Baltimore County nursing home, has been recommended by the home for admittance to a state mental hospital. This is her fourth home in a year, each having passed her off to the next, recommending that she is mentally ill and needs treatment. When finally screened by the state, she was found to be confused and showing bizarre behavior due to increasing senility. The screening committee felt she

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should stay in the home as she had some mental deterioration due to age and was not mentally ill, and felt the homes had been pressing for commitment because she was a difficult patient who required extra staff time and they would like to be rid of her.

Based on the above discussion and examples, the Commission recommends:

- Expand Geriatric Evaluation Service to include all patients in Maryland being recommended for placement in state mental hospitals to ensure appropriate referral. In addition, develop better cooperation with community and other institutional services to ensure that more appropriate alternatives be found for all older adults in need of services.
- Develop a pre-discharge planning staff in each hospital to identify those most able to re-enter the community, and work with Geriatric Evaluation Service in finding the most appropriate community services; and
- Develop a clear and comprehensive policy which would set out a model for community-based domiciliary care. This model should take into account facility size; facility location; patient mix; and, required social services.

COMMUNITY CARE

In no area of the system of care for the elderly is there more fragmentation than in community services. Federal, state, and local government, as well as voluntary agencies, revamp, revitalize, and restrict programs independently of each other, leading to tremendous gaps, overlap, and some outright duplication of community services. Because there is no broad assessment mechanism that can evaluate what services and programs actually exist, and because (in some cases) agencies want to protect information they have, it is almost impossible to determine what services are presently available for the elderly.

The fragmentation of services in the community makes it difficult for a potential recipient to find the service or combination of services needed to prevent premature institutionalization. Presently he or his family must assess the individual problem and begin contacting agencies, the names of which are found through conversations with friends or neighbors, hoping one will respond. If the individual's needs change, he must begin the process again, since there is no continuum of responsibility by agencies to ensure that follow-through is maintained. For the elderly the cracks between segments of a service continuum are gaping holes, impossible to avoid.

Even if the fragmentation could be even partially eliminated through a statewide system of community service screening and evaluation, for some, adequate services would still not be available.

Example: Mr. Q., 55, has multiple sclerosis and, although his physical mobility is limited, his mind is clear and he is able to perform minor tasks such as eating. He is currently in a large nursing home in a room with three

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senile patients. His doctor has told his minister (his only visitor) that with a trained home-health aide for a few hours daily, a homemaker twice a week, and a Meals-on-Wheels volunteer, he could remain in the community. As of this date, such a range of services could not be found and Mr. Q. remains isolated and alone in a facility whose acute services he does not require.

The community services needed for Mr. Q. were clearly identified, and yet, because of a long waiting list for Meals on Wheels and cutbacks in the homemaker service program, he had no alternative choice to institutionalization. It thus appears that the bulk of money and effort is going to provide institutional care rather than to provide adequate community services and easy access to them.

Example: Mr. Z., 57, is suffering from a rare chemical imbalance which has left him mentally and physically impaired. Though he is partially bedridden, his wife has been able to care for him at home without great difficulty, supported by his small but adequate pension; most medical bills have been covered by his company insurance. In February 1973, Mrs. Z. was diagnosed as having cancer of the lymph glands, with only a few months to live. The daughter wanted to care for her father but worked part time and could not afford to have someone come in while she was gone. Mr. Z.'s insurance did not cover such expenses and because of his pension, he was not eligible for Medicaid. Home help could not be worked out and Mr. Z. had to be admitted to a nursing home.

Homemaker services, provided through the local departments of social services, has ceased for 31 percent of those presently served because of a change in federal regulations. The new regulations limit homemaker services almost exclusively to adults receiving public assistance. An individual on a fixed income of more than \$100 a month such as a pension, is not eligible for homemaker services, even if the only alternative is institutionalization.

Another inconsistency is to be found in the financial eligibility requirements for services under Medicaid. The state reinforces institutionalization as a primary alternative through dual Medicaid eligibility regulations. In the community, for physicians, home health aids, and other non-institutional services, an individual may have a monthly income of no more than \$150, but in a nursing home he may have no more than \$2,500 in assets, but up to \$190 to \$200 (or even \$210) in monthly income.

Even community services that charge on a sliding scale can be too expensive for some, particularly those on low fixed income. Medicare is becoming increasingly restrictive, to the point where it now covers less than half of medical bills, which forces recipients to use more and more of their meager incomes for basic medical needs, allowing less for supportive community-based programs.

Thus, fragmentation of existing community services, inadequacy of important supportive services, and prohibitions by Medicare impede the

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development of comprehensive community alternatives to institutionalization. The Governor's Commission urges, therefore, the following recommendations:

- Develop a statewide information, referral, and follow-up service for the elderly;
- Fund and staff services to the elderly in the community such as daycare centers; visiting-nurse services; homemakers; community mental-health centers; transportation; foster care; and protective services;
- Develop better payment mechanisms for community services. For example, raise the allowable income under Medicaid for those 65 and over;
- Reimburse families for care of an elderly person in their homes;
- Work for inclusion of special allowances for OAA recipients under the new Social Security rulings;
- Work for legislative changes that give priority to health care in the community rather than institutionalization.

Conclusion: This summary does not contain all the answers to issues of long-term care and its alternatives. Indeed, it does not deal with all of the questions or dilemmas facing the community. It does, however, reflect the combined work of a seven-member commission which devoted its efforts over an 18-month period to identifying major problem areas and seeking realistic solutions.

The efforts, however, of this Commission, the many professionals in the health and social-service field who gave of their time and efforts, and the consultants who contributed to the final document are not enough to bring about change. What is required are the combined efforts, concern, and actions of the entire Maryland community. Unless the public is concerned enough to demand that the legislature and state officials enact laws or initiate administrative policies to improve the situation the recommendations contained in the report will mean nothing.

A concerned governor called for this report, public monies paid for its development, public servants contributed to its publication, and now—you, the community, must demand implementation of its recommendations.

RECOMMENDATIONS

GOVERNMENT AND LONG TERM CARE

- I. The Commission recommends the creation of an Office on Aging, independent of existing departments. It should have the authority, responsibility, and resources to carry out the following assignments:
 - Carry out all Titles of the Older Americans Act as amended;
 - Have the power to receive and direct future programs as established through amendments to the Older Americans Act;

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- Establish and operate a retirement information and referral service for the aged. This service shall provide information, counseling, linkages, and appropriate follow-up in the areas of health, social services, pre-retirement and retirement counseling, recreation, education, housing, nutrition, and legal services;
 - Have the power to review and make recommendations on proposed or altered state plans and programs that could have an impact on services and programs for the elderly. Such state plans and programs could be submitted to the Office on Aging before their official implementation;
 - Have the power to develop, coordinate, and assist in the location of funding for statewide geriatric screening and evaluation centers. These centers would be linked to the appropriate health and social service facilities serving specific geographic areas;
 - Have power to evaluate, analyze, and make policy recommendations to the governor, state legislature, and existing state departments in the long term care area, including (but not limited to) social, medical, nursing, and recreational services;
 - Prepare and submit a budget;
 - Have the power to conduct public hearings, compel witness attendance, examine them under oath or affirmation, and require the production of any books, records, documents, or other evidence. The director may designate the deputy director, or any other person, to administer oaths and affirmations in any proceedings or hearings.
- II. An independent audit should be made of claims paid by the Medical Assistance Program (Title XIX) for persons age 65+ for care in extended care facilities in the calendar years 1971 and 1972, in order to determine whether, and to what extent, payment for possible reimbursement through Medicare (Title XVIII) has not been determined in advance of MAP payment.

If this preliminary audit shows extensive disregard of possible payment of charges through Medicare, a more intensive analysis should be made to include all providers of services and to determine which have failed in substantial numbers to submit claims for Medicare reimbursement prior to seeking payment from MAP.

To ensure that the elderly receive the added advantages of Old Age Assistance, and particularly to make certain that they have qualified for both aspects of Medicare (Hospital Insurance and Supplementary Medical Insurance), the Secretary of Employment and Social Services should, by rule,

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require that all persons receiving assistance under the programs of Aid to the Permanently Disabled and General Assistance be automatically transferred to Old Age Assistance on reaching age 65. Moreover, to ensure qualification for Social Security benefits (including Medicare), all such recipients who had not previously done so should be required to file for eligibility at least six months before reaching age 65.

- III. During the past 18 months, this Commission has repeatedly been told that major problems centering around quality of patient care could be relieved if the State of Maryland would raise its current reimbursement rate under Title XIX. This belief has been voiced by proprietary facilities, voluntary non-profit institutions, professionals in the long term care field, and officials in state and local departments of health and social services.

Although there is validity to the argument for raising reimbursement rates, it cannot be counted on as a panacea. New rates must be coupled with carefully developed, stringent regulations that can translate higher reimbursement into quality care. To cope with this problem, a unique approach has been developed, which appears below as a recommendation. The Commission feels that it is potentially more workable as an alternative to the present system and therefore superior to current legislation, including House Bill 820, recently signed into law.

- The State of Maryland would contract with nursing homes selected by the Department of Health and Mental Hygiene to make available at all times a certain number of beds for patients who come from acute hospitals and are now hard to place. The contract arrangement begun as a pilot project with three homes would operate with the following components:
 - (1) A certain number of beds in a particular home would be allocated for patients coming in under the contract, and these beds would not be used by other patients in the home.
 - (2) The homes that are selected would be reimbursed by the state, whether or not the bed was being used—this reimbursement rate would be decided in the contract and would not be based on individual patient cost, but would be considerably higher than the current \$18.00 limit.
 - (3) All patients under the contract would come from acute hospitals.
 - (4) The homes chosen to participate would be certified as being capable of caring for the very ill patients placed there through the contract.

THE COMMUNITY AND LONG TERM CARE

- I. It is recommended that the State Department of Health and Mental Hygiene expand the Geriatric Screening and Evaluation Centers as follows:

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- There should be a center in every county;
 - The centers should include those elderly seeking health services in the community, as well as those being committed to state mental hospitals. The responsibilities of the centers should be expanded to include a mechanism for following the recipient through the system of community services.
- II. The Commission recommends a statewide Information, Referral, and Follow-up Service for the elderly within the Office on Aging. It should include:
- A 24-hour information service for the elderly and their families;
 - A follow-up program to ensure that referrals are completed;
 - A comprehensive, up-to-date, statewide catalog of services and programs available to the elderly.
 - A regular evaluation of community services to assess the degree to which there are gaps and overlaps in services and programs for the elderly. This information should be made available to groups planning programs and services for the elderly.
- III. A better payment mechanism for community services should be developed in order that home health care may become a genuine alternative for a sick or disabled adult. For example:
- State regulations should be changed to raise the allowable income under the Medical Assistance Program for those age 65 and over (it is now \$150 a month for one person);
 - Regulations should be changed to expand coverage for health-related community services under the Medical Assistance Program to include such items as transportation to and from clinics and payment of homemaker services for those not on public assistance;
 - Include home health care services in Blue Cross/Blue Shield policies for persons under age 65.
- IV. The Social Security Amendments of 1972 provide for federal takeover of three adult programs on January 1, 1974, in a program known as Supplemental Security Income. However, there is no provision for special allowances such as those now in effect to enable disabled adults to remain in home settings such as intermediate care, house keeping, special-diet grants, and the inclusion of the needs of a spouse in the payment. It is recommended that these supplemental allowances continue through the appropriation of state funds.
- V. It is recommended that state and local agencies dealing with services to the elderly (particularly the Department of Health and Mental Hygiene and the Department of Employment and Social Services)

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expand day-care centers, visiting nurse services, homemakers, community mental-health centers, transportation programs, foster-care programs, and protective services.

INSTITUTIONS AND LONG TERM CARE

- I. It is recommended that a non-profit ombudsman office be established to:
 - Serve as a negotiator and patient advocate for individuals in long-term care facilities; it should serve as a link between patients, families, facility personnel, and state agencies;
 - Provide concise, up-to-date information regarding federal, state, and local procedures for patient evaluation, certification, and financing;
 - Facilitate the identification and appointment of representative payees through close cooperation with the Social Security Administration.
- II. It is recommended that there be a social work program in every nursing home as a condition of licensure. In addition, more strenuous efforts should be made to provide social services to patients and their families before or at the time they enter the nursing home. As part of their training program, administrators should take courses in social work in nursing homes, in order to better understand the importance of this service.
- III. It is recommended that certified training programs for paraprofessionals be developed in community colleges and nursing homes and that this training be completed by every paraprofessional hired. The hiring of certified paraprofessionals is also recommended as a condition of licensure.
- IV. It is recommended that each nursing home be associated with a medical director, who will be responsible for the development and implementation of the medical-care policies of the facility and that his responsibility and authority be clearly defined.
- V. It is recommended that levels of care be eliminated for those patients now classified as chronic, skilled, intermediate A, and intermediate B. Instead, each patient, before entering a long-term care facility, would be evaluated in terms of his unique problems and potential. Incorporated into the evaluation would be individual criteria by which his progress can be measured.
- VI. It is recommended that reimbursement rates for nursing home care be realigned; present rates do not account for the variance in amounts of

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nursing care needed by long-term care patients. Instead, a "patient reasonable cost" reimbursement, similar to that now used in general hospitals, should be made.

- VII. Until the time when recommendations V and VI (or a variation thereof) are implemented, it is recommended that the required minimum amount of nursing care be upgraded to at least 2.5 nursing hours per patient per day. For homes having at least 50 percent total care patients, the minimum should be 3.0 nursing hours per patient per day.
- VIII. It is recommended that the state definition of chronic care be reevaluated. There are two types of chronically ill, those in need of rehabilitation and those for who rehabilitation would be of little or no benefit. The state claims to provide care to both groups, but in fact provides care only to the first. The state should analyze the provision of adequate care for chronic patients and either provide more beds in the state chronic hospitals, or, preferably, encourage the increase in number of beds, existing in nursing homes. (The availability of beds in nursing homes for chronic-care patients would be based on a system described in recommendation III of the Government and Long Term Care).
- IX. It is recommended that a centralized registry of beds for long-term care be organized and operated within the State Department of Health and Mental Hygiene to:
 - Enable patient-discharge personnel in acute facilities, and the families and friends of patients, to immediately locate appropriate long-term care beds;
 - Require that (within guidelines to ensure that the nursing home can actually provide the care required by the patient) homes take some total-care patients (those most difficult to place) as beds become available.
- X. It is recommended that legislation be enacted to allow the Medicaid program in Maryland to deviate from Medicare guidelines in the area of personal laundry reimbursement. The Medicaid program should be directed to seek allowance through the proper federal and state channels to allow for reimbursement of this item. During the period in which the above recommendation is being processed, the individual nursing home should be restricted to using no more than \$8 per person, per month, for personal laundry expenses.
- XI. It is recommended that bookkeeping regulations regarding patient spending money be redefined to ensure that the patient or his designee

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gets the appropriate amount and that it is not mingled with funds for nursing home operations.

- XII. Maryland law should require that the names of anyone with *any* financial interest in a nursing home be made a matter of public record; the existing legislation requires that only those with a 10 percent or more interest be declared.
- XIII. Nursing homes should be required by law to make their actual costs and profits a matter of public record. This legislation is needed because 60 to 70 percent of their funds are from public monies.
- XIV. Guidelines should be drawn stating the conditions under which a physician could be a principal physician for more than one home.
- XV. It should be illegal for pharmacies or drug firms to have financial interest in nursing homes or in real estate utilized by nursing homes.
- XVI. Guidelines should be drawn stating the conditions under which a physician could own an interest in a nursing home. Such guidelines should include regulations as to the physician's role as principal physician in a home in which he has a financial interest.

The introduction to this section was prepared by the Commission staff.

B:

The Government and Long-Term Care

Throughout this report there are frequent references to complex problems at all levels of government in providing health and social services to the aged of Maryland. These problems range from the lack of a single state agency to act for the aged citizen, to the increasingly serious problem of Medicare underutilization and its concomitant, Medicaid overutilization.

Given the overall increase in governmental involvement in the provision of services to the aged and the chronically ill, it was inevitable that this investigation would uncover a plethora of unmet needs, ill-conceived programs, and institutional lethargy. The faults are discussed in the belief that amelioration of the major problems facing the elderly will be more likely if government seizes the initiative.

The first report in this section is concerned with the lack of a single agency with the authority to coordinate programs for the aged in Maryland and act as their advocate to improve services for them. This report proposes an Executive Order to remove the State Commission on Aging from the Department of Employment and Social Services and place it within the Governor's office. In addition to increased independence, the Commission on Aging's duties would increase substantially to reflect its new roles of coordinator and advocate.

The second report in this section deals with the problems involved with Medicare and Medicaid remaining the principal financial base for long-term-care facilities. Of particular importance is the increasing reluctance of nursing facilities to utilize Medicare as a payment source and the inevitable increased reliance upon Medicaid. Our chief concern is that Medicaid may become so overburdened that the state administration will tighten its regulations to the point that the medically indigent will find themselves suffering from an even greater lack of health services.

While these reports are critical of intergovernmental operations, it is pointed out that the problems are not due in the main to lack of concern or from incompetence—but are the inevitable result of a system torn by fragmentation.

1:

Office on Aging

The lack of clear public policy toward the aging continues to be a major problem in Maryland. The Commission believes, as do many other public and private individuals, that lack of a coordinated effort by the various government departments concerned with aging has created a policy vacuum and that the fragmentation creates frustrations at all levels that adversely affect the services to our old people.

The Commission will look, therefore, at other organizational models—fully aware that any new model for administration of state services must be both politically and economically feasible. Toward these ends, it has developed this proposal to create a new form for service delivery and management. The proposal pulls together existing programs and resources into a comprehensive unit with the power to mobilize energy around particular problems. The proposed changes should require few, if any, new personnel but rather, would be a process whereby existing programs dealing with the aged are coordinated by the new unit. In this way we will maximize the use of skilled manpower, while at the same time avoid the possibility of creating yet another bureaucracy with little direction or effect.

The argument is sure to be raised that the aged and chronically ill are being selected for special effort and other groups equally in need or at risk are being ignored. While not denying the need of other groups, this Commission believes that there are times when the need for direct action is immediate and critical. In 1972, in this state and this nation, the time for action to help our old people is now. There are some 300,000 elderly in the state of Maryland, many of whom need the help of state programs and services. The Commission proposes a new unit to help these citizens get the support and services they need.

The new Office of Aging would be for the overall operation, coordination and advocacy of statewide programs for the elderly and chronically ill. It would have as its underlying philosophy the concept of a continuum of services, which would allow the aged or chronically ill person to be treated as a whole person.

The Proposal: Section 1. (1) The Office on Aging is hereby established as part of the Executive Office of the Governor of Maryland. The Office on Aging, with a Senior Citizens Advocacy Commission, and Interdepartmental Committee on Aging, shall be the principal state agency for:

- (a) Administration and coordination of basic policy and priorities with respect to the development and operation of programs and activities conducted within the state under the Title III and Title VII provisions of the Older Americans Act of 1965, as amended;
- (b) Coordination, continuing assessment and evaluation of other state and local, public and voluntary, programs important to the well-being of the state's older population, including programs in such areas as income maintenance, public health, mental health, housing and urban development, employment, education, recreation, rehabilitation of the physically or mentally handicapped, and especially programs and services of agencies and facilities (proprietary, non-profit or publicly owned and operated) providing care and services to older persons in such licensed facilities as nursing homes, boarding homes and other facilities providing care to older persons;
- (c) Systematic development of a statewide comprehensive, coordinated system of social and community services for older persons and their families, in order to secure and sustain maximum independence and dignity in the community for older persons capable of self-care; to avoid unnecessary institutionalization of older persons, which results when indispensable social and community services are either not available or inaccessible;
- (d) Development of education and training opportunities for programs serving older persons (including training for older persons themselves) in the state's various educational systems, including the University of Maryland, the state colleges, and the community colleges;
- (e) An annual report to the Governor and the General Assembly setting forth the recommendations of the Office on Aging, and its Senior Citizens Advocacy Commission, for the improvement of state, local, and federal programs and services to better meet and serve the needs and interests of Maryland's older population.

The head and chief executive officer of the Office on Aging shall be the Executive Director. The Executive Director shall be a person with demonstrated competence and experience in programs serving older people. There shall also be a Deputy Director of the Office on Aging who shall assist the Executive Director in the performance of the Executive Director's duties. The Executive Director and Deputy Director shall be appointed by the Governor and chosen from a list of acceptable candidates provided by the Office on Aging's Senior Citizens Advocacy Commission. The Executive Director and Deputy Director shall serve at the pleasure of the Governor. However, the Governor may not remove the Executive Director or Deputy Director without prior consultation with the Advocacy Commission. The Executive Director and Deputy Director shall receive such salaries as are provided in the state budget. The Executive Director shall report directly to the Governor and shall, subject to the authority of the Governor, be

responsible for carrying out the powers, duties, responsibilities and functions vested in the Office on Aging.

(2) , The State Commission on Aging is hereby abolished. All rights, powers, duties, obligations and functions heretofore conferred upon or exercised by the State Commission on Aging and the office of the Director of the State Commission on Aging, shall be transferred to, and shall, subject to the authority of the Governor of the State of Maryland, be exercised by the Office on Aging.

(3) All rules, regulations, forms, orders, and directives promulgated by or in effect for the State Commission on Aging shall continue in force unless, and until, changed by the Executive Director of the Office on Aging or the Governor of the State of Maryland.

(4) All references in this Code, other laws, ordinances, resolutions, rules, regulations, directives, appropriations, legal actions, contracts, or other documents to the State Commission on Aging shall be deemed to mean the Office on Aging.

(5) All persons who are officers and employees of the State Commission on Aging, but not including the members of the Commission or the Director and Associate Director, are hereby confirmed in the office, position, and classification which they now hold as officers and employees of the Office on Aging until they retire, resign, or are removed as provided by law.

(6) *Definitions:* As used in this article: a) "The Office" means the Office on Aging established by Section 1A of this Article. b) "The Commission" means the Senior Citizens Advocacy Commission. c) "The Committee" means the Interdepartmental Committee on Aging. d) "Aging" means those individuals sixty (60) years and older and their spouses.

(7) *Senior Citizens Advocacy Commission* (a) There is hereby created and established a Commission to be known as the Senior Citizens Advocacy Commission, to be appointed by the Governor and to consist of a member of the State Legislature; a representative of voluntary agencies serving the elderly; a representative from the County Commissions on Aging; a representative of the Medical-Chirurgical Faculty; three independent consumers (age 60 or over); a representative of the proprietary long-term-care industry; a representative of the non-profit long-term-care industry; a representative of the social services sector; a representative of the Social Security Administration; a representative of senior citizens organizations; a representative of public health nurses; a representative of organized labor; a representative of industry, with the Executive Director and Deputy Director serving as ex-officio members of the Commission. The Commission shall have at least five members age 60 or over. The Chairman and Vice-chairman shall be chosen by the Commission members.

(b) The term of office of each of the appointive members of the Commission shall be for three years, provided however, that of the members first appointed, five shall be appointed for terms which will expire December 31, 1973; five for terms which will expire on December 31, 1974; and five for terms which will expire on December 31, 1975. Vacancies shall be filled by appointment for the unexpired terms. The appointive members shall continue in office until their successors are appointed and have qualified. An appointee shall be eligible for reappointment. Any appointed member shall, during his term, serve at the Governor's pleasure, and such member may be removed by the Governor at any time prior to the expiration of his term.

(c) The Commission shall meet at least once a month in each year, and special meetings may be held at the call of the Chairman. The Office on Aging shall provide housekeeping, secretarial, and consultant services to the Commission. The Commission shall submit an annual report to the Governor and Legislature.

(d) The members of the Commission shall receive no compensation for their services but shall be reimbursed for all expenses actually and necessarily incurred by them in the performance of their duties as herein set forth within the amount made available by appropriation therefor. The members of the Commission appointed from outside state government shall not be deemed state employees.

(e) The Commission shall have no executive or appointive duties. It shall advise the Governor and the Office on Aging in connection with:

- (1) Formation of a comprehensive plan for short and long-range development through the utilization of federal, state, local, private, and voluntary resources, of adequate services and facilities to, and for, the aged individuals in Maryland and revision from time to time of such plans.
- (2) The promotion, development, establishment, coordination, and conduct of unified programs in the areas of health, social services, education, and employment in cooperation with other federal, state, local, private, and voluntary agencies.
- (3) The evaluation of existing and planned programs administered by the Office on Aging.

(8) *Interdepartmental Committee on Aging:* (a) There is hereby created and established a committee to be known as the Interdepartmental Committee on Aging and to consist of the Secretary, or his principal deputy from the Department of Health; the Commissioner, or his principal deputy, from the Department of Mental Health; the Secretary, or his principal deputy, from the Department of Employment and Social Services; the Secretary, or his principal deputy, from the Department of Education; the Secretary, or his

Office on Aging

principal deputy, from the Department of Economic and Community Development; a representative from Comprehensive Health Planning, a representative from the Department of State Planning; the Secretary or his principal deputy from the Department of Transportation; the Director of the State Retirement System; and the Director and Deputy Director of the Office on Aging. The chairman shall be the Executive Director of the Office on Aging.

(b) All members of the Committee shall be permanent members.

(c) The Committee shall meet at least every third month in each year, and special meetings may be held at the call of the chairman. The Office on Aging shall provide housekeeping, secretarial, and consultant services to the Committee.

(d) The members of the Committee shall receive no compensation for their services, but shall be reimbursed for all expenses actually and necessarily incurred by them in the performance of their duties as herein set forth within the amount made available by appropriation therefor.

(e) The Committee shall have no executive appointive duties. It shall advise the Governor and the Office on Aging in connection with:

- (1) Coordination of programs and services affecting the elderly;
- (2) Planning new and modified programs and services;
- (3) Reviewing pending, proposed, and existing state legislation affecting the elderly;
- (4) Analyze the impact of federal legislation and regulations concerning the elderly, particularly as they affect more than a single state agency; and,
- (5) Submission of an annual report by each department or program represented, on its activities in the aging field, to the Office on Aging, and other reports or analyses from the member departments of the Interdepartmental Committee as may be deemed necessary.

(9) *Powers and Duties:* Any exercise of its powers and duties by the Office on Aging shall be made subject to the approval of the Governor. The Governor may, at his discretion, exercise or perform any power, duty, responsibility, or function, which the Office on Aging is authorized to perform under the provisions of this article or under any other provisions of law.

The Office on Aging shall:

- (a) Carry out Titles III and VII of the Older Americans Act as amended, which include Title III (Grants for Community Programs on Aging); and Title VII (Nutrition Programs for the Elderly).

- (b) Have the power to receive and direct future programs as established through amendments to the Older Americans Act.
- (c) Establish and operate a retirement information and referral service for the aged and near aged. This service shall provide information, counseling, linkages and appropriate follow-up in the areas of health, social services, pre-retirement and retirement counseling, recreation, education, nutrition, legal services, and housing.
- (d) Have the power to review and make recommendations on proposed or altered state plans and programs which could have an impact on services and programs for the elderly. Such state plans and programs must be submitted to the Office on Aging prior to their official implementation.
- (e) Have the power to develop, coordinate, and assist in the location of funding for statewide geriatric screening and evaluation centers. These centers would be linked to the appropriate health and social service facilities serving specific geographic areas.
- (f) Have power to evaluate, analyze, and make policy recommendations to the Governor, legislature, and existing state departments in the long-term-care area, included (but not limited to) social, medical, nursing, and recreational services.
- (g) Have the power to assist in the development of alternative choices for the aged through the planning and delivery of community and home-based services and innovative programs for institutionally based services.
- (h) Prepare and submit a budget.
- (i) Have the power to conduct public hearings, compel witness attendance, examine them under oath or affirmation, and require the production of any books, records, documents or other evidence; and the Director may designate the Deputy Director or any other person to administer oaths and affirmations in any proceedings or hearings.
- (j) Have, and exercise, all powers necessary or proper to effect any or all of the purposes of the Office on Aging pursuant to this article.

This report was prepared by the Commission staff.

2:

Financing Nursing Home Care Under Medicare and Medicaid in Maryland

Nursing-home patients are for the most part, elderly. Expenditures in fiscal year 1971 in the U.S. for nursing-home care for persons 65+ amounted to an estimated \$3,129 million, while for the age group 19-64 the figure was \$210 million, and for those under 19, only \$25 million. Estimated governmental expenditures in that year for nursing-home care for persons 65+ was \$1,878 million, of which \$1,090 million were from federal funds and \$789 million from state and local funds.¹ (Table 1)

Medicare Part A (Hospital Insurance) financed from contributions of employees matched by employers, and by the self-employed, is a primary source of funds for care of the elderly in nursing homes, until recently designated in the Social Security Act Title XVIII as "extended care facilities."² The Maryland Medical Assistance Program (Medicaid) bears the costs of Medicare co-insurance and deductibles in extended-care facilities and the costs of care not paid from Medicare in skilled nursing homes for persons 65+ who are receiving Old Age Assistance or have been declared medically indigent.³

An examination of the trends in expenditures from these two major sources of financing of nursing-home care for the elderly is an essential component of an assessment of the nursing-home resources in the state.

Decline in Financing of Extended Care under Medicare (Title XVIII): In recent years the Social Security Administration has increasingly restricted claims for care in extended care facilities which it has honored under Medicare (Title XVIII). National figures on the extent of the decline in Medicare reimbursement for care in extended care facilities are shown in Table 2. In 1968 over 1 million claims for extended facility care were approved, representing 12.9 percent of all claims, but by 1970 the number had dropped to only 583,000, or 8 percent, of all claims. In dollar terms, the amount of reimbursement for extended care declined in these years from over \$343 million in 1968 (8.8 percent of all claims paid) to a slightly over \$213 million in 1970 (4.5 percent of all claims paid).⁴

Although the Commission on Nursing Home's staff has heard many complaints from nursing homes about the restrictive policies in Medicare, including retroactive denials of payment, and although it is known that many facilities no longer will accept Medicare cases, no systematic analysis has been made of the matter within Maryland. The nature of some of the restrictions imposed by the changes in policy by the Social Security Administration has been pointed out in the following testimony before the Senate Subcommittee on Health of the Elderly by Dr. Joseph Pesare, medical care program director of the Rhode Island Medical Assistance Program.⁵

One of the underlying reasons for the increased expenditures for skilled nursing home care must be attributed to the recently-imposed rigid interpretation of policy pertinent to qualification for admission to extended care facilities as conceived by Federal Medicare.

Since 1969, very few cases have been approved for the maximum 100-day extended care facility allowance under the provision of Federal Medicare (Part A), therefore making it necessary for Medical Assistance to assure responsibility for the payment of the full cost of nursing home care at a time earlier than the anticipated maximum of 100 days.

The following prerequisites are required for Medicare coverage in an extended care facility.

(A) The services furnished must be required for:

- (1) Treatment of a condition or conditions for which the beneficiary was receiving in-patient hospital services prior to transfer to the extended care facility:*
- (2) Treatment of a condition which arose while receiving in-patient hospital services.*

(B) A physician's certification (and recertification when services are provided over a period of time) is required.

- (1) This must include an estimate of the time required to accomplish rehabilitation:*
- (2) Certification that treatment of this condition or conditions requires skilled nursing care (not exclusively limited to R.N. or L.P.N. services but must include other paramedical services such as physical therapy and occupational therapy) on a continuing basis.*

(C) Interpretation of Skilled Service—Are Too Restrictive

- (1) The classification of a particular service as skilled is based on the technical or professional health training required to effectively perform or supervise the service. For example, a patient following instructions can normally take a daily vitamin pill. Consequently*

the act of giving the vitamin pill to a patient who is too senile to take it himself would not be a skilled service.

- (2) The importance of a particular service to an individual patient does not necessarily make it a skilled service. For example, a primary need of a non-ambulatory patient may be frequent changes of position in order to avoid development of decubiti. Since changing of position can ordinarily be accomplished by unlicensed personnel, it would not be a skilled service.*
- (3) The possibility of adverse effects from improper performance of an otherwise unskilled service does not make it a skilled service.*
- (4) In addition to meeting the definition of skilled nursing services, the services must be needed on a continuing basis. For example, a person may require intramuscular injections on a regular basis every second day. If this is the only skilled service required, it would not necessitate the continuing availability of skilled nurses.*

Financing Nursing Home Care for the Aged Under the Maryland Medical Assistance Program: That the aged are the predominant age group whose nursing-home care is financed by the Maryland Medical Assistance Program (MAP) is shown in Tables 3 and 4. It will be noted that of 7,074 persons receiving nursing-home care under MAP in the fiscal year 1972, there were 5,971 persons 65+, or 84.4 percent (Table 3). Of total payments for nursing-home care of \$18,086,235 in the same year, \$15,423,944, or 85.2 percent, was in behalf of persons 65+ (Table 4).

The trends in number of individuals 65+ receiving service under MAP, and the effect it has upon MAP expenditures, are shown for the fiscal years 1968 through 1972 in Tables 5 and 6. The decline in numbers of persons 65+ after 1969 is undoubtedly attributable to the transfer of intermediate care to the State Social Services Administration, which is discussed in the following section. In all five years, nursing-home expenditures for the aged represented 60 percent or more of the total MAP expenditures.

Payment for Care in Intermediate Care Facilities: Financing the care of needy adults in intermediate care facilities (ICF) has shifted from the MAP program to public assistance and back to MAP within a period of four years, each transfer of responsibility resulting from an amendment to the Federal Social Security Act. In 1969 ICF care was transferred to the then State Department of Social Services and was returned to the Department of Health and Mental Hygiene in January 1972. In the interim, the number of persons under care increased from slightly over 500 in July 1969 to slightly over 3,000 in January 1972.

The number of ICF cases classified as Old Age Assistance increased from 479 in August 1969 to 1,395 in July 1970; to 1,966 in January 1971; to

2,790 in January 1972. In the latter month, 2,070 of these aged patients were in the counties and 720 in Baltimore City.

The average payment for all adult cases in January 1972 was \$360.98 in the counties; \$383.54 in Baltimore City; with a statewide figure of \$366.85.

Elsewhere, the Social Services Administration has attributed the increase in persons 65+ in ICF care to the following factors:

... the increased cost of the provision of care, the increasing number of persons needing this type of care who have exhausted their resources and the Health Department evaluation and transfer of approximately 60 percent of persons previously receiving skilled nursing care to the intermediate care level.⁶

This shift in responsibility for payment of care undoubtedly accounts for the decline after 1969 in persons 65+, whose care in nursing homes was paid from MAP funds, as shown in Table 5. It is important to compare the January 1971 figure of 1,966 persons 65+ in ICF care with the figure of 5,827 persons of that age group in skilled nursing homes in fiscal 1971. The actual number of adults transferred from skilled nursing homes (SNH) to ICF or the number of homes declassified from SNH to ICF in the period from July 1969 through January 1972, cannot be ascertained. Moreover, no data as yet is available on the trend in caseload since MAP took over ICF in January 1972.

Possible Under-Utilization of Medicare: Based on preliminary evidence presented pointing toward possible under-utilization of Medicare by some providers which, in turn, results in over-utilization of MAP, the Commission on Nursing Homes on December 27, 1972 wrote to the lieutenant governor, with copies sent to the U.S. General Accounting Office and the regional office of the Medical Services Administration, Social and Rehabilitation Service, Department of Health, Education, and Welfare:

This Commission is greatly concerned about any possible cutbacks in the Medical Assistance Program in Maryland because increasingly this has become the principal third-party source for payment of nursing-home care as payments through Medicare have declined. Also, studies currently under way show that payments for home health care, an important program enabling elderly and handicapped persons to remain in their own homes, have been extremely limited and the staff will urge the Commission to recommend that the MAP program take more positive leadership in the expansion of home-care programs through lifting some of the present technical restrictions on financing.

We have read various news reports of the findings and recommendations of the 40-member committee which has recently reviewed the MAP program. As a means of reducing MAP costs, the emphasis appears to be on tighter control of eligibility including the use of State Police, on one hand, and peer review of acute-hospital care, on the other.

We believe there is strong preliminary evidence that there could be substantial savings in MAP through less stringent and simpler measures. Our findings indicate that

there may be substantial under-utilization of Medicare in payment for general hospital care resulting in over-expenditure of MAP funds for this purpose.

Subsequent information supports the preliminary evidence of under-utilization of Medicare. On December 21, 1972, the Comptroller General of the United States issued a report to the House Committee on Ways and Means entitled *Functioning of the Maryland System for Reviewing the Use of Medical Services Financed under Medicaid*. The following paragraph from that report supports the suspicion that the Medicaid claims review process might not be wholly effective:

Maryland's utilization review system does not provide for the systematic accumulation of data showing the claims reviewed and approved or disapproved and the amounts of reductions in claims. The availability of such data would enable management officials to (1) identify the providers who repeatedly file unreasonable claims and the recipients who repeatedly overuse the program so that their participation in the program may be restrained or stopped. (2) analyze overutilization of medical services to identify general trends and develop methods of avoiding such overutilization and (3) make cost-benefit analyses of review activities.

Statistics on MAP for fiscal year 1972 (dated October 16, 1972) were not made available to the Nursing Home Commission's staff until February 12, 1973 when they were publicly released (see Tables 4, 5, and 6).

In Table 5, it will be noted that the number of persons 65+ receiving in-patient hospital care financed through MAP increased from 7,319 in 1969 to 8,685 in 1971, although the total number of aged provided services in that period was about the same in 1971 (45,575) and in 1969 (45,836).

Even more significant, however, was the increase in persons 65+ receiving in-patient hospital care under MAP in 1972 as compared with 1971. The number of aged rose from 8,685 to 11,520, an increase of 32.6 percent. The total number of persons receiving all services under MAP increased in that period, as did the total number receiving in-patient hospital care. Nevertheless, the percentage increase of persons 65+ receiving in-patient care under MAP (32.6%) was greater than the total percentage increase (22.4%) and exceeded that of any other age group (See Table 7). This higher rate of increase in the one age group covered by Medicare is further evidence of possible under-utilization of Medicare for general hospital care in Maryland.

December 27, 1972

Honorable Blair Lee, III
Lieutenant Governor of Maryland
State House
Annapolis, Maryland

Dear Lt. Governor Lee:

This Commission is greatly concerned about any possible cutbacks in the Medical Assistance Program in Maryland because increasingly this has become the principal third-party source for payment of nursing-home care as payments through Medicare have declined. Also, studies currently under way show that payments for home health care, an important program enabling elderly and handicapped persons to remain in their own homes, have been extremely limited and the staff will urge the Commission to recommend that the MAP program take more positive leadership in the expansion of home-care programs through lifting some of the present technical restrictions on financing.

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We believe there is strong preliminary evidence that there could be substantial savings in MAP through less stringent and simpler measures. Our findings indicate that there may be substantial under-utilization of Medicare in payment for general hospital care, resulting in over-expenditure of MAP funds for this purpose.

The basic evidence was first pointed out in the Maryland Commission on Aging's report on health care of the aged issued in November 1971. This brought out that for the fiscal years 1967, 1968, and 1969 Maryland ranked 51st among the states, including the District of Columbia, in the number of general hospital admissions per 1,000 Medicare enrollees. The report stated "... the matter warrants investigation by health and hospital officials."

Analysis of similar data for the calendar year 1970 made by the Nursing Home Commission again showed that Maryland had the lowest rank among the states in general hospital utilization by Medicare enrollees.

Informal and confidential testimony from knowledgeable individuals confirmed the assumption that there was under-utilization of Medicare for general hospital care. Comments were made to the effect that the Medicare procedures were complex and that an additional claim had to be filed to receive reimbursement for the deductibles and co-insurance through Medi-

caid. As one person put it, "Why bother with Medicare when you can get it all handled more conveniently through Medicaid?"

Other circumstances suggest under-utilization of Medicare by general hospitals. The MAP billing form for inpatient hospital care at the very bottom of a full page of fine-print instructions explains the procedures to be followed with respect to patients 65 years of age and over. (There was a letter sent in 1972 to all providers of services dealing with billing procedures for patients 65 years of age and over through the Medical Services of the District of Columbia, the intermediary agency for Montgomery and Prince George's Counties). In contrast, private physicians were furnished a 3-page set of instructions for processing claims for persons 65 and over in 1970. This was followed by a clear and less formal set of instructions in February 1972. According to a press report, the 40-member study committee found MAP expenditures for acute hospital care mounting at a rapid rate while claims for care by private physicians were declining.

The tables referred to above which show Maryland's low hospital admissions proportionate to Medicare enrollment were presented to the official in the Medical Care Programs Administration responsible for the unit that processes MAP claims. He asserted that the claims were checked for possible Medicare eligibility in the following manner: the billing form contains an 11-digit patient identification number. The next to the last two digits show the year of patient's birth. If this shows that he is 65 or older, it is to be returned to the provider. In a large office area crowded with clerks working with piles of papers, it was incredible that any consistent manual review of this or the birth-date item in the claims actually took place. The Commission staff had no authority to inspect the process. Moreover, this official said he would look over the tables and mentioned that the 40-member commission was meeting that afternoon. Nothing has been heard about the matter subsequently.

The problem was later formally referred to the Medical Services Administration, U.S. Department of Health, Education, and Welfare, whose representative reported that the matter had been taken under advisement but that no early action was contemplated.

With no mention made of the possibility of Medicare under-utilization in press reports of the findings of the 40-member committee, the problem was presented to the General Accounting Office in Washington. The evidence as outlined above was reviewed in a conference with the Director of the Manpower and Welfare Division of GAO and the Associate Director of the Division for Health. These officials assured the staff that the preliminary evidence warranted further investigation, and that an independent auditor could review the claims through a simple sampling process which could be expanded if first soundings suggested the need for an extensive review. The officials stated that GAO did not take on a case of this sort from a state

agency because the responsibility for such an audit in their view rested with the state's own auditing authority.

Consequently we are presenting the matter to you with the hope that an independent audit might be made of the MAP claims processes with particular respect to hospital inpatient claims. Furthermore, we would suggest that if the practice of short-circuiting of Medicare by hospitals appears to be as prevalent as it appears, it would be in the public interest to probe further to determine whether the practice is widespread among hospitals or whether certain individual institutions are the principal offenders.

There is another area related to possible under-utilization of Medicare at the expense of MAP in which the exploration by the staff of the Commission has reached a dead end. This has to do with whether the State Department of Employment and Social Services has made sufficient effort to require that persons receiving public assistance qualify for Medicare eligibility sufficiently in advance of reaching the age of 65 that they would immediately be entitled to health care benefits under Part A of Medicare upon reaching 65. Also, it is not known whether the buy-in for Part B in behalf of persons 65 and over receiving public assistance as required effective July 1970 is actually taking place routinely.

Suspicion that qualification under Medicare was not being effectuated arose from the fact that the state public assistance manual merely "recommends" that persons receiving Aid to the Permanently Disabled be transferred to Old Age Assistance upon reaching the age of 65 even though it is to the advantage both to the individual and the state that this shift be made. Upon inquiry addressed to the Department, the Commission learned that in June 1972 there were 1,301 persons 65 years of age and over in Baltimore City receiving aid under programs other than Old Age Assistance. Data were not available from the county departments of social services. The possible relationship of this to the under-utilization of Medicare was brought to the attention of the Department of Employment and Social Services by the staff of the Commission. A reply was received which is incomplete. For example, the letter contains no reference to transfer to Old Age Assistance from Aid to the Permanently Disabled, the principal program in question.

It should be pointed out that as a result of efforts by the Federal Social Security Administration, hundreds, if not thousands, of employers throughout the nation arrange for their employees approaching age 65 to file for Social Security eligibility three months before reaching 65 so that they would immediately be eligible for Medicare benefits should a medical problem arise. Since the Commission is powerless to pursue this matter further, it is also brought to your attention as another possible avenue for conserving MAP funds.

Again may we stress the importance of conserving MAP funds which are

Government and Long-Term Care

so much needed for the payment of nursing-home care and for the expansion of home health care services.

Sincerely yours,

Paul A. Kerschner, Ph.D.

Financing Nursing Home Care

TABLE 1: Estimated expenditures for nursing home care for three age groups, 1971. (Source: B. S. Cooper and N. L. Worthington, "Medical Care Spending for Three Age Groups", *Soc. Sec. Bull.* (May 1972), pp. 3-16.)

Age group	National average per capita (dollars)	Total national (millions of dollars)	Total governmental (millions of dollars)		
			State and local	Federal	Total
Under 19	0.33	25	8	8	15
19-64	1.84	210	56	77	133
65 and over	150.86	3,129	789	1,090	1,878

TABLE 2: Number of claims for payment in extended care facilities approved, percent of total claims, amount paid, and percent of total payments under hospital insurance (Medicare part A), 1967 to 1970. (Source: Social Security Administration, *Social Security Bulletin, Annual Statistical Supplement 1970* (Washington, D.C.: Government Printing Office, 1970), table 112, p. 114).

Calendar year	Approved claims		Amount Paid	
	(No.)	(%)	(Thousands of dollars)	(%)
1967	784,426	11.0	\$240,662	7.7
1968	1,003,466	12.9	343,221	8.8
1969	892,156	11.8	324,025	7.3
1970	582,551	8.0	213,083	4.5

TABLE 3: Maryland Medical Assistance Program: Number of persons receiving service, by type of service and age, for fiscal year 1972. (Source: Maryland Department of Health and Mental Hygiene, Center for Health Statistics).

Type of service	Age group				Total (all ages)
	Under 6	6-20	21-44	45-64	65 and over
One or more service*	49,772	123,010	85,109	50,369	50,440
Hospital inpatient	6,016	12,764	18,572	10,162	11,520
Nursing home	0	4	140	959	5,971
Hospital outpatient	30,989	67,309	50,173	28,043	18,269
Physician	33,266	74,625	60,215	37,403	32,320
Pharmacy	37,574	77,097	67,157	42,313	42,121
Dental	2,610	36,175	24,910	9,443	4,377
Home health	43	61	227	628	822
Special services	1,842	17,374	17,969	15,258	12,386
					358,700
					59,034
					7,074
					194,783
					237,829
					266,262
					77,515
					1,781
					64,829

*The number of persons who received any service or combination of services under the entire program. The figures, therefore, are not the same as the total number of persons receiving service by type of service.

TABLE 4: Maryland Medical Assistance Program: Payments, by type of service and age, for fiscal year 1972. (Source: Maryland Department of Health and Mental Hygiene, Center for Health Statistics).

Type of service	Payments per age group (dollars)				Total payments (dollars)
	Under 6	6-20	21-44	45-64	65 and over
Hospital inpatient	5,258,118	8,800,339	19,375,772	18,441,669	3,685,942
Nursing home	0	15,457	322,657	2,324,177	15,423,944
Hospital outpatient	1,759,492	3,598,950	4,555,699	3,177,899	923,538
Physician	972,829	1,888,739	3,108,409	2,499,107	1,452,574
Pharmacy	561,744	1,119,251	2,639,432	3,388,859	4,497,873
Dental	75,807	1,694,870	2,733,375	1,207,148	460,121
Home health	1,887	6,633	26,067	89,552	51,789
Special service	22,994	308,116	404,689	538,392	396,019
All services	8,652,871	17,432,355	33,166,100	31,666,803	26,891,800
					55,561,840
					18,086,235
					14,015,578
					9,921,658
					12,207,159
					6,171,321
					175,928
					1,670,210
					117,809,929

TABLE 5: Maryland Medical Assistance Program: Number of individuals age 65 and over receiving service, by type of service, for fiscal years 1968 to 1972. (Source: Maryland Department of Health and Mental Hygiene, Center for Health Statistics).

Type of service	Fiscal year			
	1968*	1969*	1970*	1971
Hospital inpatient	7,698	7,319	8,317	8,685
Nursing home	5,905	6,132	5,589	5,827
Hospital outpatient	14,942	14,704	16,109	15,690
Physician	28,349	31,938	33,800	28,723
Pharmacy	38,002	36,546	39,699	38,646
Dental	2,017	1,777	2,541	3,148
Home health	306	663	751	782
Special services	3,275	2,426	5,044	8,071
All services	45,196	45,856	47,406	45,575

*The figures for 1968, 1969, and 1970 do not include data on Medicaid funds (Title XIX) for care in state mental, chronic disease, and tuberculosis hospitals or the University of Maryland Hospital. They also do not include data from clinics operated by local health departments. The same exclusions apply to 1971 and 1972, except that figures for University of Maryland Hospital are included.

TABLE 6: Maryland Medical Assistance Program: Expenditures for individuals age 65 and over by type of service for fiscal years 1968 to 1972. (Source: Maryland Department of Health and Mental Hygiene, Center for Health Statistics.)

Type of service	Expenditures per fiscal year (dollars)			
	1968*	1969*	1970*	1971
Hospital inpatient	1,364,367	1,794,886	2,421,672	2,574,618
Nursing home	12,059,998	12,470,188	12,619,553	13,998,160
Hospital outpatient	554,317	619,107	771,196	662,985
Physician	856,830	1,329,941	1,539,551	1,062,485
Pharmacy	3,151,821	2,748,142	3,668,617	3,723,572
Dental	179,787	84,191	172,498	280,448
Home health	19,364	51,778	73,770	59,110
Special services	100,264	35,527	111,787	211,994
All services	18,286,748	19,128,760	21,378,644	22,573,372

*The figures for 1968, 1969, and 1970 do not include data on Medicaid funds (Title XIX) for care in state mental, chronic disease, and tuberculosis hospitals or the University of Maryland Hospital. They also do not include data from clinics operated by local health departments. The same exclusions apply to 1971 and 1972, except that figures for the University of Maryland Hospital are included.

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TABLE 7: Maryland Medical Assistance Program: Number of persons receiving all services and number receiving inpatient hospital care, by age, for fiscal years 1971 and 1972. (Source: Maryland Department of Health and Mental Hygiene, Center for Health Statistics.)

Age group	1971		1972		Increase in hospital inpatients, 1971-1972 (%)
	All services	Hospital inpatient	All services	Hospital inpatient	
Under 6	42,318	5,148	49,772	6,016	16.9
6-20	101,781	10,154	123,010	12,764	25.7
21-64	108,719	24,240	135,478	28,734	18.6
65 and over	45,575	8,685	50,440	11,520	32.6
All ages	298,393	48,227	358,700	59,034	22.4

References

1. Cooper, B. S. and Worthington, N. L. "Medical Care Spending for Three Age Groups, *Soc. Sec. Bull.* (May 1972), p. 3.
2. The term "skilled nursing home" has been used in Medicaid (Title XIX). The Social Security Amendments of 1972 substitute the term "skilled nursing facility" for both "extended care facility" and "skilled nursing home" as previously used in the statute.
3. Responsibility for the costs of care of Old Age Assistance recipients in Intermediate Care Facilities was transferred to Medicaid under an amendment to the Social Security Act effective January 1, 1972.
4. The reader is reminded that Medicare has been limited to persons age 65 and over, and will continue to be until July 1, 1973, when coverage will be extended with certain limitations, to recipients of Disability Insurance Benefits under provisions of the Social Security Amendments of 1972.
5. U.S. Senate, Special Committee on Aging, Subcommittee on Health of the Elderly, *Cutbacks in Medicare and Medicaid Coverage* (Washington, D.C.: Government Printing Office, 1972), part 3.
6. (Baltimore: Department of Employment and Social Services and Maryland Commission on Aging, 1971), *Maryland's Older Citizens* Part 2, p. 10. For further discussion of the financing of Intermediate Care, see this volume and part 3.

This report was prepared for The Commission by Robert T. Lansdale.

C:

The Community and Long-Term Care

At the hearings conducted by the Senate Subcommittee on Long-Term Care at the time of the Salmonella outbreak, the statement was made that at least twenty percent of the patients in nursing homes should not be there. If appropriate community support services were available, these people could have remained in their homes.

This statement summarizes the problem facing the elderly and those working with the elderly—that the choice of whether a person remains in the community or goes to an institutional setting many times is not his or his family's to make. The inadequacies of support services force the premature removal from the home setting. One of the chronic reasons given for lack of development of adequate services is the shortage of funds. It is ironic that because of lack of funds, unnecessary institutionalization occurs, since it is far more expensive to maintain a person in an institution than it is to help him maintain himself in his own home.

As more and more studies point up the negative effects of institutionalization, especially when it is unnecessary, and as cost studies show what is actually paid into institutions for patient care, a realization is being made that better and more complete home and community services need to be developed. However, community services should not be seen only as a means of preventing or postponing institutionalization. Far more importantly, community services enable those served to enhance their quality of life.

Presently community services are fragmented, both in substance and in sponsorship. Because of this fragmentation, it becomes difficult for the potential user to identify which services are most appropriate for him, as well as whether or not they are actually available. Many times, out of frustration in not identifying and finding what he needs, he gives up and waits until his situation reaches a crisis, at which time someone might intervene in his behalf.

The fragmentation makes documenting the need and the existence of community services a difficult task. Yet, without documentation it becomes

difficult to influence the initiation, improvement, and augmentation of services through the necessary channels of legislative action, budgetary increases, and organizational realignments.

In order for the Commission as well as other groups to be able to exert the necessary influences needed for positive change, studies have been undertaken by the Commission to attempt to illustrate the extent and types of community services available in relation to their need. At best the studies are incomplete because of the difficult nature of the task, but they can serve as a beginning to more extensive work in the future.

1:

Report on Geriatric Evaluation Services Statewide and on the requirements for Expanded Service in one Geriatric Center on a Demonstration Basis.

RATIONALE

Between 1970 and 1980, world population is expected to increase by 28%, according to the United Nations, but the aged population is expected to increase by 38%.

In old age, multiple disabilities increase. The frequency and duration of hospital admissions increase. According to Elliot Richardson, then Secretary of HEW, the number of persons 65 years of age or older cared for in nursing and personal care homes increased by 47% between 1963 and 1969 while the number of such persons in the population increased by only 9%.

Funding mechanisms have weighted the alternatives for impaired older persons in the direction of institutional care; only recently has some shift toward community services been apparent, although largely in the form of governmental advice rather than in available funds.

As Dr. Robert Morris of the Levinson Gerontological Policy Institute, Brandeis University, testified before the Special Committee on Aging, U.S. Senate:

"... We have relied on medicine (and latterly on rehabilitation) to remove or to overcome nearly all hazards of existence. If we cannot wholly prevent disease and injury, some therapy is expected to patch up individuals well enough to go on living without further help. Thus, both Medicare and Medicaid spend \$12.7 billion of public funds annually, but 67% goes for doctors' bills, drugs and for hospital treatment. The 0.3% devoted to home health care is paid for short-term nursing related care."

Citing the sub-marginal allowances provided for the disabled who are unable to work and who, in fact, must incur extra expenses just to maintain themselves beyond the requirements of other public assistance clients, Dr. Morris continues:

"... The paradox is that our programs pay too little to keep such persons at home" (after January 1974, \$130 a month, for a single person living home, substantially above the present average public assistance level) "but will readily pay an average of \$400-\$500 a month to keep the same person in an institution."

Community and Long-Term Care

A survey of aged Medicaid recipients in Massachusetts nursing homes indicated that from 25%-50% do not require such care, findings consistent with studies in many other states. The kind of care required by the population studied is given in the following diagram:

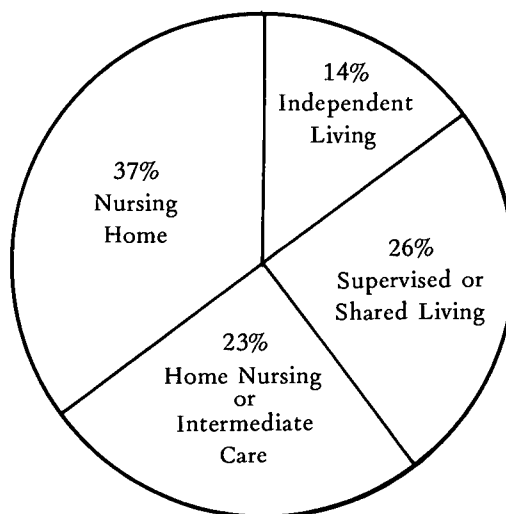


FIGURE 1
ESTIMATED APPROPRIATE PLACEMENT OF
CURRENT INSTITUTIONALIZED ELDERLY*

*Based upon data derived from Massachusetts Department of Public Health studies, 1969.

Although a small fraction of the total aged population is currently institutionalized, estimated at about 5% (it may have increased since the last tabulation was made), many aged persons living in the community do not have adequate care or services:

In a cross-national study conducted by Shanas, Townsend, etc. of aged living in the community, they report in "Older People in Three Industrial Societies" that:

10% of all aged are bedfast at home, the majority of whom have no frequent contact with medical or professional nursing personnel.

65% of the aged receive help from families in housekeeping and financial aid but about 25% rely exclusively for such help on persons or agencies outside the family.

Although about 40% live with spouse (usually also aged) and about 35% with others, mainly children or siblings, almost 25% live alone.

About 10% are in urgent need of home help services, especially visiting services and day centers. Not only are these and other services required for the benefit of old people themselves but also for families who, although willing to care for them, require some respite from demands made on them

from day to day without let-up or during crises in the family. Spouse and siblings are likely to be or become disabled themselves; as the average life span increases, the children of aged parents are themselves approaching senescence.

In testimony before the Special Committee on Aging of the U.S. Senate, Dr. Robert Morris of the Levinson Gerontological Policy Institute, Brandeis University, charged:

"While we pay generously for active treatment, and modestly for basic shelter, we pay nothing to reinforce the natural life system arrangements to which the disabled can turn in their own communities. The entire burden is placed upon family and neighbors who usually help for a time, until they are virtually bankrupted in money and energy; then the unfortunate individual is removed to a nursing home. Instead of reinforcing and conserving these natural family and friendship supports, they are permitted to exhaust themselves until only much more costly alternatives remain available.

"The explanation for this seemingly illogical policy lies, perhaps, in a natural reluctance to face the fact that there are some hazards of human existence which cannot be prevented or removed by therapy. There are some ugly handicaps with which individuals can and do survive and with which society must learn to live. This reluctance to consider ongoing handicaps also produces a grave imbalance in our public policy and in our service programs. These conditions call for a mix of medical and social provision, but our current pattern is heavily balanced on the side of medicine, and grossly under-developed on the side of social provision."

Principles Considered in Planning Geriatric Assessment Center *Demonstration Project

1. Evaluation of the older person's strengths and disabilities in the context of his social situation is essential to effective care.

The aged tend to receive only perfunctory assessment. Disabilities which in younger people would be explored are in the aged still too often dismissed after cursory examination as "natural" concomitants of aging to be endured rather than treated or are ascribed to "senility," an irreversible organic condition, for which appropriate "disposition" now or at some future time is the only issue.

2. Evaluation must be an on-going process, repeated as the older person's condition or circumstances change.

3. Thorough evaluation must be a team effort; in old age particularly, disability results from multiple, closely inter-related factors: medical, psychiatric and social.

4. The concept of functional assessment and functional restitution is particularly useful in evaluating and treating the aged individual for whom some deficits will probably persist and others intrude in time. The objective is practical: to assist the individual to function satisfactorily in his chosen life style and within the circumstances open to him by treating those

*The term Geriatric Assessment Center is used to distinguish this comprehensive service from more limited but similar programs now in operation.

disabilities which can be reversed or ameliorated, altering those circumstances which lend themselves to change and helping him, with environmental aids and supportive services, if necessary, to contend with remaining disability.

5. The effectiveness of evaluation is largely vitiated if a range of care alternatives, health and social, is not available, and if the delivery system, in terms of outreach and hours, is not adapted to patient requirements.

6. Provision for continuity of care should be built into the program because the population to be served is at high risk: fluctuations in condition or circumstances are common and new trauma or altered living situations may nullify a plan of care satisfactory even the day before.

DESIGN OF MODEL PROJECT

In the interests of orderly planning and sound administration, the comprehensive services and full coverage envisioned for a Model Project will have to be phased in. At each stage, experienced staff, tested services and receptive consumer group should precede expansion.

In order to proceed as rapidly as possible to a full scale Model Project, the site(s) for Geriatric Assessment Center(s) should be selected from among those counties with already effectively functioning geriatric evaluation and pre-discharging planning programs. Other factors to be considered are resource potentials in the subdivision for expansion of services and demonstrated cooperativeness among agencies.

Target Population

Eventually Geriatric Assessment Centers should be available to any aged person, or to others on his behalf, who needs assistance in maintaining or regaining maximum functional independence in relation to impending or present mental/physical disability.

About 25% of the population aged 65 and over is estimated to be in this category. In Maryland, according to the Assessment Study published by the Maryland State Commission on the Aging in 1972, 55,000 out of 300,000 aged have some degree of restricted mobility and of that group 19,500 need assistance in getting out of the house and 14,000 are homebound. Other risk factors, like problem drinking, recent bereavement, sensory deprivation, etc. are associated with needless personal deterioration and likelihood of admission to long term care facilities.

It is not possible to gauge accurately the extent of need or the degree to which services, if available, would be used. That the number far exceeds those now applying for admission to long term hospitals and other types of facilities is evident from the overwhelming response whenever the limited services presently available in local Health Departments are publicized.

GAC services should initially be limited to those presently served by Geriatric Evaluation, Discharge Planning Services and, on a selective basis, applicants for nursing homes and ICF admission, expanding instead resources for more adequate evaluation and institutional alternatives. Estimates of cost benefits can be gained most immediately from this group.

Good results are, however, more likely to be obtained by earlier intervention. Consequently, coverage should thereafter systematically be expanded, dropping the age limit and eligibility criteria as GAC experience and resources warrant.

Although the aged constitute the primary goal of GAC, this population is selected not simply because they are old but because the incidence of multiple chronic illnesses and other impairment is disproportionately high in later years. Many younger adults are equally impaired and could profit by many of these same services.

Income

No income limitations should be set. Many of the services proposed are not available even to those who can well afford to pay for them. After an experimental period, fees should be charged according to ability to pay, by third party payment or waived for those with marginal resources.

Initially, however, service should be made available without cost although contributions can be accepted. The aged, anxious about future catastrophe, are fearful of spending slender resources. They are concerned about imposing on family. As proof of their worth, although dependent, many old people husband their savings to bequeath to their children, often going without themselves. Impaired old persons frequently share the same fatalism about the inevitable progression of disability that is common among the community at large; furthermore, they are likely to resist help because once their circumstances are known to others institutionalization may be arranged, a fear not without substance.

If GAC is to reach the people who need the service most, fee requirements for the service should not be allowed to intrude. The State and Federal governments, as well as the individual, have a stake in reducing disability and over-utilization of in-patient facilities.

Once GAC is an established service this policy should be reviewed.

Components of Service

Personal evaluation by an inter-disciplinary team is the core service from which other GAC functions derive and to which they are related.

With these services, GAC will serve as the hub of a developing comprehensive system of care for the aged, linking existing services to each other and linking the patient to the services he needs. In this sense, then, GAC will supplement rather than duplicate existing services (private

physician, public health nurse, social agency, health facilities, etc.) and in identifying unmet needs will encourage development of resources within the community rather than creating under its own auspices services to fill these gaps.

1. *Individual evaluation.* Individual assessment of medical, psychological and social factors by a competent, experienced team comprising at a minimum medicine, nursing and social work with consultation as needed readily available from medical specialties, including psychiatry, and from Occupational and Physical Therapy and from the legal profession.

Patients will be evaluated in their own homes or other residence or at the Center.

Scheduling of evaluation visits should entail no long delays and should allow for occasional crisis intervention.

GAC teams will initiate and maintain contact with the patient's personal physician, serving as consultant to him regarding further diagnostic procedures and future planning. If the patient has no personal physician, GAC will arrange for further diagnostic studies if necessary and will refer the patient to appropriate resources for continuing health care.

Following evaluation, the team will not only recommend a plan of care but remain available to patient, family, personal physician or other caregivers to assist them in implementing it or modifying recommendations to adapt to difficulties encountered.

Patients may be re-evaluated at intervals as changes in the patients' condition or circumstances suggest.

Back Up Services

a. Adequate evaluation may occasionally require more extensive tests or period of observation. GAC will need to have cooperative arrangements for laboratory work, out-patient clinic and day hospital resources as well as for brief in-patient admission to acute general or special hospitals and skilled nursing homes.

b. Occasionally patients referred for evaluation are homeless or at such immediate risk in their present residence that temporary shelter is needed in order to complete the assessment or to implement the recommendations. For this purpose, GAC should have cooperative arrangements for brief admission to skilled or intermediate care facilities with payment by Medicaid assured if patient is eligible.

2. *Monitoring.* Following evaluation and assistance in implementing a care plan, GAC will retain no responsibility for on-going treatment or casework service but will continue to keep in touch with the patient either directly or through persons responsible for his care to learn if he is receiving services needed and if any change has occurred in his condition or circumstances.

The frequency of such contacts will be individually determined. Recommendations following evaluation should therefore be explicit as to duration and expectation to indicate appropriate intervals for follow-up. A tickler system is desirable.

In dealing with an impaired population, continuity is essential not only for the patients' benefit but also to obtain feedback about the validity of GAC recommendations and, perhaps, even more important, information about the natural course of the patient's progress and effectiveness of the system in adjusting to his changing needs.

The annual review required of Medicaid patients in nursing homes, mental hospitals and other facilities could be integrated into this monitoring system. GAC might also have in-put into the Utilization Review or PSRO procedures.

3. *Consultation.* Service to physicians, social agencies, families and others in which the knowledge of the GAC team is utilized to discuss problems in the patient's care without involving GAC assessment of the patient himself.

As the comprehensive type of evaluation offered by GAC is adopted by other health care resources, referrals for consultation may be expected to increase and referrals for evaluation to decrease.

4. *Information and Referral.* As a result of its other functions, GAC will be called for information about resources and should be adequately staffed to answer inquiries and make suitable referrals, thereby supplementing Information and Referral Services already available under other auspices.

5. *Inventory of needed resources.* GAC will maintain records to document for future planning the kind of services required, including those not yet available, and the willingness of older people and their families to use them.

With this objective, GAC will record for each case evaluated its optimal recommendation and the actual disposition, accounting for any disparity by indicating whether the desirable service was not available, the individual not eligible or unwilling to use.

Auspices

It is suggested that at least for the purposes of a Model Project local Health Departments, already funded to provide some of the GAC functions described above, serve as administrative unit for expanded grants, coordinating their Geriatric Evaluation and Pre-discharge Planning Units.

Local Health Departments will supply many of the support services required by patients referred to GAC: Home Health, public health nursing, loans of equipment, review for level of care of SHD 29 applications for admission to nursing homes and related facilities, approval of special services for Medicaid payment, etc.

In any case, for a service emphasizing patients' care in the community, a community based health agency is more likely to assure the essential frame

of reference as an in-patient facility is less likely to do. Nevertheless, of course, close liaison is necessary with a variety of health care services.

Training

Provision should be made for training of all GAC personnel in modern methods of geriatric assessment and continuing care. Few professionals in this country already have this specialized competence, however experienced and skilled they may otherwise be.

Supportive Services

The effectiveness of evaluation will rely on the options available for implementing a plan of care.

Funding of the Model Project should therefore include expansion or initiation of supportive services, especially Community Home Care Services described in recently enacted legislation (S219), Day Care for the Elderly (H275), Home Health and Meals on Wheels.

These and similar services will be administered by independent agencies and not incorporated in GAC. However, in order to assure availability of these options to GAC patients, purchase of service agreements or other contracts might be considered; arrangements between GAC and the major agencies offering supportive services should also include explicit arrangements for participation of representatives in GAC planning for individual patients and for development of a system of community care.

The Personal Care Organization pattern proposed by the Levinson Gerontological Policy Institute at Brandeis University might be worth considering to simplify application for and flexibility in administration of a range of social or personal care services now offered piecemeal by various agencies with differing eligibility criteria.

Program Evaluation

Effectiveness of the Project should be evaluated at intervals by competent professionals not involved in performing or administering the services. Evaluation should include not only effectiveness of service to the individual but also cost-benefit effectiveness for possible future expansion to other areas of the state.

Obviously methods of data collection have to be built into the program from the beginning and the evaluators related to program purpose and development.

We suggest that the Department of Health and Mental Hygiene, perhaps through the Administration for Services to the Chronically Ill and Aged, be responsible for program evaluation. If two experimental units are set up, rural and urban, a centralized evaluation process would be particularly

desirable in order to identify areas of likeness and difference in their operation. Furthermore, a program evaluation unit located at state level would have access to data from other Administrations and would also be responsive to the needs of the DHMH for data regarding cost off-set, budget projections, etc.

Funding

The amount of State money required to fund this proposal depends on several variables:

1. Extent to which parts of GAC are already funded in a given locality
2. Decision to designate a rural and an urban area for demonstration
3. Limits initially imposed on potential case load or amount of service offered.

It is anticipated that the Project could be funded from a variety of sources, including Federal Programs and private sources, with a relatively small in-put for matching purposes from the State.

Extension of Present Geriatric Evaluation Service Statewide

With one exception all counties with substantial admission rates of aged to state mental hospitals now have a Geriatric Evaluation Service.

In many of these counties, however, a significant number of aged patients by-pass pre-admission evaluation and will probably continue to do so unless a firm policy is adopted for prior referral to Geriatric Evaluation Service. Such a policy could be more clearly stated and consistently enforced if it had statewide applicability.

For this reason, we urge that the means for pre-admission evaluation be available statewide as soon as possible. However, the volume of referral in the remaining counties does not warrant establishment of a team in each unit.

Instead we recommend use of one of the following alternatives, depending on local circumstances:

1. Mental health clinics be asked to do the evaluation
2. Mental hospital staff be assigned to visit and evaluate these patients in the community
3. Contracts be made with local Health and Social Services Departments staff for reimbursement per evaluation.

*This report was prepared for the Commission by a Sub-Committee
Chaired by Helen Padula*

2:

Plan for a Statewide Information and Referral Service for the Elderly

Introduction

It has become increasingly clear to the Governor's Commission on Nursing Homes that effective utilization of institutional and community services by the elderly and their families can only come through an information and referral service. This service, available to everyone in the state seeking information, would do the following:

- (1) Provide a complete centrally located data bank on services available to the elderly.
- (2) Provide information about institutional and community services to the elderly, their families, agencies and institutions, and anyone else who needs it.
- (3) Provide information to:
 - (a) help educate consumers and agency staff about available services;
 - (b) help reduce consumer frustration about agency services;
 - (c) work against inappropriate use of existing services;
 - (d) help increase choice of services.
- (4) Provide summary data every six months showing who is using services, what services are available and where these services are located, duplication of services, gaps in services.
- (5) Maintain contact with state and local planning groups, individual agencies, and institutions to insure that the data bank is continually up to date, and to help them develop coordinating mechanisms to more effectively deliver quality services.
- (6) Provide follow-up to insure that the individual being referred actually ties into the service he needs, and to document that the agency actually provides the services it claims to be providing.

A. Organization of the I and R Service: The statewide I and R service for the elderly would be part of the State Commission on Aging in the Governor's office. It will operate as 24 local units, one in each county and Baltimore City. It should be organized locally because:

(1) Local telephone numbers and local staff can be used, use of a WATS line has not been very successful in I and R programs. (2) The local services could apply for county funding. (3) As data is gathered in conjunction with the program, it can be used to help make program planning better on the county level as well as on the state level.

B. Staff—State: director, field staff (3); research analyst, research assistant, administrative assistant, secretaries (2)

Baltimore City: director, tracking and follow-up specialists (2), administrative assistants (2)

Prince George's, Montgomery, Baltimore and Anne Arundel counties: director, tracking and follow-up specialist, administrative assistants (2)

All other counties: director, tracking and follow-up specialist, administrative assistant.

The tracking and follow-up specialists would be hired three to six months after the program begins. (In addition, there is a possibility that Senior Aides—under the State Commission on Aging Senior Aide Program—could be used as part of the tracking and follow-up program). The local I and R staffs will be trained by the state staff.

C. Responsibilities of the State and County offices: The state office would run the central data information center, provide training to new staff in local I and R programs, provide technical assistance and support to county offices, provide requested information to the local I and R units, and evaluate the program every six months, both in the counties and in the state and distribute the evaluation reports.

The county offices would provide the information and referral service, record basic data on calls received and send copies to the state, maintain liaison with local agencies in order to insure information is kept up to date, send updated information to the state office and provide follow-up services.

D. Data System: The service will use the United Way of America UNSIS ID system and text. This system is being used with success in other places, including Hampton Roads, Va. The system would operate from a centralized data bank. Every six months the data bank would print out everything available in a particular county and send it to that local I and R service. In addition, every month it would send out an update on the material. In the meantime, the local program would send back to the central data bank any changes or additions about services in the county. It would be the

responsibility of the local I and R programs to keep the information about the area up to date.

E. *Twenty-four hour service*: The service would be 24 hours a day, seven days a week. After working hours—9:00-5:00 Monday thru Friday—the phone would be switched to rotating staff or volunteers working out of their homes. Even though the full catalog of service sources won't be available, emergency referrals could be made, but more important, a supportive person would be answering the phone.

F. *Telephone procedures*: The I and R service would accept calls and give the necessary information, if available. The trained staff (both the director and the administrative assistants would be trained in telephone procedures) would also give needed support over the phone—but not formal counseling. As a rule, the staff would not call the agency the person is being referred to, but instead let the person inquiring do this himself. However, if the person is upset or has difficulty, the I and R staff could call the agency and make the referral.

G. *Information gathered*: The following basic information on each call would be recorded (unless the individual prefers not to give some information): Name, address, county, phone, sex, age, type of request, type of response. This would be recorded on a simple form in duplicate with each month one copy being sent to the central office.

H. *Follow-up*: Within six months of the beginning of the new statewide I and R program, the following follow-up program would be developed: (1) The county office would telephone everyone for whom a referral was made (assuming a telephone number is available) three months after the initial call to see if the desired results were obtained. (2) The county office would make home visits to a sample of people who had been referred but who could not be reached by phone. (3) The county office would make home visits to those people having continuing difficulty getting their needs met or who have difficulty articulating their needs by phone.

The purpose of the follow-up program is to insure that those who call I and R are put into contact with the parts of the system they need. Through the follow-up program, an evaluation can be made of the degree to which individuals can get services they need as a result of calling the I and R service.

I. *Evaluation*: Every six months the state I and R service would evaluate the program, based on the data gathered by the counties. The evaluation would include: (1) statistics on calls made to I and R; (2) breakdown of referrals made; (3) breakdown of referrals completed and not completed and show reasons why referrals were not completed.

The evaluation data should be sent to all concerned agencies (agencies that

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can or should be affected by what is shown in the reports). From the continual evaluation process would come assessments of needs and gaps which would help program planning on both the county and state levels.

J. Implementation in the counties: Presently, there are several local I and R services in the state. In order to make the statewide I and R politically feasible, these local services need to be consulted to discuss the feasibility of the service and of their possible participation. If they are accepted into the state service, it could provide technical assistance and support.

K. Agency use: Agencies themselves throughout the state could use the service, which might help develop coordination among agencies.

This report was prepared by the Commission staff.

3:

Alternative Choices for Adult Care: Supportive Home Services

A catalog of programs in Maryland to enable elderly, disabled, or handicapped adults to remain at home.

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Introduction: Nursing homes are an important choice for an adult no longer capable of self-care. Within this broad classification of group-care facilities, there are choices in quality, quantity (availability), level of care, location, and cost.

This report deals with the other side of the problem, with the other choices available to the incapacitated adult that may enable him or her to remain in their own home, that of a relative or friend, or a substitute private home. These are termed "supportive home services." A genuine choice for the elderly, however, exists only when a cluster of supportive services are available, i.e., financial, medical, social, legal, nutritional, household, transport, and escort. And "available" means not only that a variety of services actually are provided in the person's neighborhood or community, but that they can easily be marshalled to provide a real choice.

PART ONE: HOME HEALTH SERVICES

For the large number of older persons whose mobility is limited by illness or disability or for whom public or other transportation is generally unavailable, health services provided in the home, and transportation and escort service to physicians' offices, hospitals, and clinics, are essential for good health care. The degree to which these needs are met in Maryland is not known. At best, a quantitative picture of agencies in the state furnishing these services can be presented.

Home Health Care:

Home Health Care can be defined as a coordinated system of individualized health care delivered to patients in their homes by professional and allied health personnel under the direction of a physician. These services are organized and provided so that the patient is either restored to full health or achieves maximal rehabilitation with the least possible disruption to his usual pattern of daily living.

Home health services include intermittent nursing care, physical therapy, occupational therapy, speech therapy, social service, home health aide, housekeeping services, laboratory investigation, medical equipment and supplies as ordered by the physician.¹

A quantitative picture of the certified agencies² furnishing home health care and expenditures for such services under the Medical Assistance Program (MAP) are presented in Table 1. The services available to patients in Maryland through certified home health agencies by county and for Baltimore City are also shown.

The services listed as available in 17 of the counties are provided by Certified Local Health Department Home Health Agencies. In Montgomery County, however, home health services are provided by the Visiting Nurse Association of Washington, D.C., under an arrangement with the county health department. In Baltimore City, home health services are supplied by

TABLE 1. Services to patients through certified home health agencies, December 1, 1972 (Source: Division of Nursing, Maryland State Department of Health and Mental Hygiene.)

Certified Local Health Department Home Health Agencies	Skilled Nursing Service	Home Health Aides	Physical Therapy	Occupa- tional Therapy	Speech Therapy	Medical Social Worker	Inhalation Therapy	Nutrition*
Allegany	x		x			x		x
Anne Arundel	x	x	x			x		x
Baltimore**	x		x	x		x		x
Caroline****	x	x	x					x
Carroll	x	x	x					x
Cecil	x	x	x					x
Dorchester	x	x	x					x
Frederick	x	x	x					x
Garrett	x	x	x					x
Harford	x	x	x					x
Howard	x	x	x					x
Kent	x	x						x
Montgomery***	x	x	x					x
Prince George's	x	x	x	x	x	x		x
Queen Anne's****	x	x	x					x
St. Mary's	x	x	x	x				x
Somerset	x		x					x
Talbot	x		x					x
Washington	x	x	x					x
Wicomico	x	x	x		x	x		x
<i>Hospital Home Care Programs</i>								
Holy Cross Hospital—Silver Spring	x	x	x	x	x	x	x	
Memorial Hospital—Cumberland	x	x	x		x	x		
Sinai Hospital—Baltimore	x	x	x	x	x	x	x	
<i>Other</i>								
West Baltimore Health Care Corp.	x	x						
Instructive Visiting Nurse Association—Baltimore	x		x				Physician and transport service	x
Leisure World—Silver Spring	x	x	x					

* Available through Maryland State Department of Health and Mental Hygiene. No fee for service.

**Part of Baltimore County served by Instructive Visiting Nurse Association of Baltimore City (see text).

***Arrangement by county for Washington, D.C. Visiting Nurse Association to provide home health care services to all of Montgomery County.

****Withdrawn October, 1972.

*****New agency initial survey November 1972.

*****male to change male catheters.

the Instructive Visiting Nurse Association, a voluntary agency, which also serves part of Baltimore County.

The Instructive Visiting Nurse Association (IVNA): This voluntary agency, which marked its 75th anniversary in 1971, provides home health services to persons in Baltimore City and within a five-mile radius in Baltimore County. In 1971, 46,443 visits were made to 6,157 patients. Of these patients, 642 (or 10.4 percent) resided in Baltimore County, the remainder in Baltimore City. The professional staff consists of 38 RNs, eight of them in administrative or supervisory positions; 16 LPNs; and 14 home health aides.

The 1971 annual report of the IVNA contains detailed data on types of services and patients served. Some of the tables are reproduced here because they show the potential of a home health care program, particularly one serving older people, many of whom might otherwise have to be institutionalized.

The number and proportion of patients by age group are shown in Table 2. It will be noted that this is a program predominantly serving older adults. More than three out of five (61.6 percent) were 45 years of age and over, and more than two out of five (43 percent) were 65 and over.

TABLE 2. Number and Proportion of Patients by Age Group.

Age Group (years)	Patients (No.)	(%)
Birth	831	13.5
Under 1	27	0.4
1 -14	109	1.8
15-24	831	13.5
25-44	566	9.2
45-64	1,146	18.6
65-74	1,321	21.5
75+	1,326	21.5
Total	6,157	100.0

Tables 3 and 4 indicate that many of these patients might have been institutionalized had not home health services been available. Table 3 shows that 85.0% of the visits were to patients with chronic illness. Table 4 shows that *Bedside Care and Treatment* was the type of professional care requiring the most visits. Moreover, the 10,889 visits for *Bedside Care and Treatment* for patients 65 years of age and over represented a figure higher than the total visits to all age groups for any other type of professional care.

The number and proportion of patients are shown by source of referral in Table 5. Hospitals accounted for nearly two-thirds of the patients. In turn, doctors were responsible for only 14.3 percent. A breakdown of figures for

Supportive Home Services

TABLE 3. Number and Proportion of Patients and Visits, by Type of Illness.

Type of illness	Patients		Visits	
	(No.)	(%)	(No.)	(%)
Acute	407	6.6	891	1.9
Chronic	3,905	63.4	39,480	85.0
Maternity	1,782	29.0	3,527	7.6
Other	63	1.0	14	
Absent Visits			2,531	5.5
Total	6,157	100.0	46,443	100.0

TABLE 4. Number of Visits by Age and Type of Professional Care (percent given in parentheses).

Professional Care	Birth-14	15-44	45-64	65+	Absent Visits	Total
Bedside care and treatment	213	424	1,992	10,889		13,518
Hypodermics	79	324	1,277	3,216		4,896
Other treatment	175	927	1,950	5,857		8,909
Message, exercise and crutch walking	32	54	321	845		1,252
Physical therapy	35	187	546	1,935		2,703
Demonstration of care or treatment	196	401	805	1,284		2,686
In behalf of patients	9	17	17	49		92
Health counseling only	1,562	2,540	1,901	3,853		9,856
Absent visits					2,531	2,531
Total	2,301 (4.9)	4,874 (10.5)	8,809 (19.0)	27,928 (60.1)	2,531 (5.5)	46,443 (100.0)

TABLE 5. Number and Proportion of Patients, By Source of Referral.

Source of referral	Patients	
	No.	%
Family and friends	1,036	16.8
Doctor	881	14.3
Health department	45	.7
Other	298	4.9
Johns Hopkins Hospital	493	8.0
Sinai Hospital	351	5.7
University Hospital	1,016	16.5
Union Memorial Hospital	948	15.4
Other hospitals	1,089	17.7
Total	6,157	100.0

referrals from governmental departments of social services or voluntary social agencies is not available.

Financing the Program: The sources of revenue for IVNA for 1971 are shown in Table 6. The grants listed in the table represent state funds received through the Baltimore City and Baltimore County Health Departments, engendered by matching funds from Community Chest. Substantial payments are also received from Medicare and Medicaid, but there are legal and other limitations in these programs which affect how much they pay for various types of medical services. Blue Cross and Blue Shield are not listed as sources of income, which will be treated in the later discussion of third-party financing.

TABLE 6. Sources of IVNA Revenue, 1971.

Source	Revenue	
	(dollars)	(%)
Patient fees	33,325	5.7
Medicare	210,390	35.9
Medicaid	101,160	17.3
Other contracts	26,217	4.5
Grants	121,764	20.8
Endowments	16,585	2.8
Community Chest	76,510	13.0
Total	585,951	100.0

Sinai Hospital Home Care Program: The Home Care Program of Sinai Hospital of Baltimore, now in its 12th year, is a good example of a hospital-based home health care service. Data presented here is taken from the 11th Annual Home Care Report for the fiscal year 1972.

A measure of the service is shown in Table 7, which shows for the past three fiscal years the number of patients discharged by age and sex. It will be noted that the patients are mostly age 65 and over. In fact, the number under 65 has been in the 40s for all three years, whereas the number 65 and over declined from 218 in 1970 to 155 in 1971, but rose to 245 in 1972. While varying somewhat from year to year, the proportion of females to males 65 and over reflects, in general, the proportion of the total population 65 and over in Baltimore in 1970.

The source of payment for home health care is shown for the fiscal years 1971 and 1972 in Table 8. In both years payment for persons 65 and over came exclusively from Medicare and Medicaid and, as would be anticipated in a hospital-based program, from Medicare, Part A (Hospital Insurance). For both years payment from Medicaid paid for slightly less than half of the patients under 65.

Supportive Home Services

TABLE 7. Discharges from homes, by sex and age, fiscal years 1970 to 1972.

Sex of patient	Age					
	Under 65		65+		All	
	(No.)	(%)	(No.)	(%)	(No.)	(%)
<i>Fiscal year 1970</i>						
Male	20	42.6	71	32.5	91	34.0
Female	27	57.4	147	67.5	174	66.0
Both	47	100.0	218	100.0	263	100.0
<i>Fiscal year 1971</i>						
Male	19	42.2	69	44.5	88	44.0
Female	26	57.8	86	55.5	112	56.0
Both	45	100.0	155	100.0	200	100.0
<i>Fiscal years 1972</i>						
Male	15	35.7	97	39.5	112	39.0
Female	27	64.3	148	60.5	175	61.0
Both	42	100.0	245	100.0	287	100.0

TABLE 8. Source of payment, by age of patient, discharges during fiscal years 1971 and 1972.

Source of payment	Fiscal Year 1972				Fiscal Year 1971			
	All Ages		Age of Patient		All Ages		Age of Patient	
	(No.)	%	65	65+	(No.)	%	65	65+
Government	259	90	19	240	177	88	22	155
Medicare A	190	66	0	190	130	65	0	130
Medicare B	33	11	0	33	17	8	0	17
Medicare B and Medicaid	17	6	0	17	8	4	0	9
Medicaid	19	7	19	0	22	11	22	0
Other	28	10	28	0	23	12	23	0
Free Care	3	3	8	0	3	2	3	0
Part Pay	16	6	16	0	16	8	16	0
Private Fee Schedule*	4	1	4	0	4	2	4	0
All sources	287	100	42	245	200	100	45	155

*Patients able to pay full charges for services—do not have third-party coverage.

This reliance on Medicare has seriously affected the program, however. The following statement from the Annual Report and the table to which it refers are the most convincing evidence that has been found within Maryland of the damage done to home care programs by the Medicare regulations which have become increasingly restrictive since 1969.

Despite these pressures to continue Home Care patients on the program longer, we have found since 1968 the average length of stay has dropped from 83.5 to 47.9 days (see Table 9). This has resulted from increasingly rigid guidelines set down by the Department of Health, Education and Welfare which have definitely changed the thrust of the Home Care Program. At the time of the program's inception Home Care

Community and Long-Term Care

was looked upon as a method of keeping chronically ill patients functioning in the community for as long as possible. It has now become a purely medical plan, and social concerns have become relatively unimportant. Home Care is now looked upon as a period of stabilization following hospitalization. Once a plateau of recovery has been reached, Home Care is withdrawn, even though this may mean the patient must leave the home and move into a nursing home.

TABLE 9. Average stay, by age of patient—comparison of five years.

Fiscal year	All ages (days)	Under 65 (days)	65+ (days)
1972	47.9	51.4	44.5
1971	52.9	50.2	53.7
1970	56.4	45.6	58.7
1969	82.0	88.0	78.0
1968	83.5	79.0	88.0

Transportation and Escort Services: No exact information is available on transportation and escort services in the counties operated primarily to enable the elderly and infirm to use health facilities, visit offices of doctors, purchase drugs, and make other necessary trips. Such services have been described by a state health professional as "inadequate or non-existent" in the counties. Baltimore City is better off, however. Following are excerpts from *Marylands' Older Citizens: An Assessment of Needs and Services (Part III)*, describing the program of the Bureau of Special Home Services of the Baltimore City Health Department, which is one of the outstanding programs of its kind in the nation.

Bureau of Special Home Services. This unit of the Baltimore City Health Department is a health service operated primarily for older, chronically-ill persons. It was established originally in 1965 as a demonstration project operated by the Health and Welfare Council of the Baltimore Area and financed from funds from the Office of Economic Opportunity. Later it was taken over by the Baltimore City Health Department. Its first full year of operation under this, its present jurisdiction, was fiscal 1968. The program's primary objectives are:

- (1) To assist people 60 years of age and older who seem chronically ill to secure and maintain meaningful connections with appropriate health and social service facilities;
- (2) To employ and utilize non-professional personnel in the giving of direct health referral and follow-up services that would strengthen client motivation for more effective use of those services;
- (3) To develop staff employment opportunities for both young and older non-professional people of low income.

Under supervision, health aides visit the homes of persons referred and accepted for services; keep in touch with these clients and their families; accompany clients to hospitals, clinics, or other agencies; arrange for client transportation when needed;

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intercede as aggressive advocates in clients' behalf; and generally do whatever is necessary to insure that needed services to clients are most helpfully given.

A few statistics provide some measure of the extent of the services performed. There were 7,250 active patients as of January 1, 1973. In the fiscal year 1972, round trips provided to health facilities totaled 13,669. In addition, escort service as provided for 2,670 adults. The average cost per patient in the first six months of fiscal year 1973 was \$85.

The staff (not including clerks) consists of the following:

Director, who is an RN; Assistant Director; Clinical Director, a physician serving part time; 3 Senior Health Aide Supervisors; 3 Health Aide Supervisors; 5 Health Aides Grade 4; 10 Health Aides Grade 3; 23 Health Aides Grade 2 (some part time); 8 Health Aides Grade 1 (some part time); 7 Chauffeurs.

Extent of Home Health Care Services Financed Through MAP: Some measures of the extent and trends of home health services for the elderly can be found in the statistics on the Maryland Medical Assistance Program (MAP) compiled by the Center for Health Statistics of the Department of Health and Mental Hygiene. Figures on the number of persons 65+ receiving home health care services under MAP and the annual expenditures for this purpose are shown for four fiscal years in Table 10. It will be noted that although the number of older persons receiving home health care services has increased from 306 in 1968 to 782 in 1971, these numbers represent only a tiny fraction of the 45,000 persons 65+ receiving MAP services in each of the four years.

The contrasts in expenditures are even more revealing of the relative insignificance of home health care services for the elderly in MAP. In 1971, for example, nearly \$14 million was paid for nursing-home care, whereas payments for home health care amounted to slightly less than \$60 thousand. While too much significance should not be attached to changes between two single years, it is important to point out that while the number of persons in the home care category increased from 1970 to 1971, the expenditures in that period declined. This may reflect a MAP policy change toward greater emphasis on short-term cases and away from long-term care, which is discussed in the following section on financing home health care.

Figures on payments for home health care services through MAP provide some measure of the extent of such services. Data on payments for home health services for the state as a whole, for Baltimore City, and for the counties is shown for fiscal year 1971 in Table 11. Health professionals in the Division of Nursing of the State Department of Health and Mental Hygiene point out, however, that payment figures are not an exact index of the extent of the services rendered by a particular home health care agency,

TABLE 10. Maryland Medical Assistance Program: Number of and expenditures for individuals 65+ receiving service, by type of service, fiscal years 1968, 1969, 1970, and 1971. The figures for 1968, 1969, and 1970 do not include data on Medicaid funds (Title XIX) for care in state mental, chronic disease, and tuberculosis hospitals, nor the University of Maryland Hospital. They also do not include data from clinics operated by local health departments. The same exclusions apply to 1971, except that figures for University of Maryland are included. (Sources: Center for Health Statistics, Maryland Department of Health and Mental Hygiene.)

Type of service	1968		1969		1970		1971	
	(No.)	(dollars)	(No.)	(dollars)	(No.)	(dollars)	(No.)	(dollars)
Hospital inpatient	7,698	1,364,367	7,319	1,794,886	8,317	2,421,672	8,685	2,574,618
Nursing home	5,905	12,059,998	6,132	12,470,188	5,589	12,619,553	5,827	13,998,160
Hospital outpatient	14,942	554,317	14,704	619,107	16,109	771,196	15,690	662,985
Physician	28,349	856,830	31,938	1,329,941	33,800	1,539,551	28,723	1,062,485
Pharmacy	38,002	3,151,821	36,536	2,748,142	39,699	3,668,617	38,646	3,723,572
Dental	2,017	179,787	1,777	84,191	2,541	172,498	3,148	280,448
Home health	306	19,364	663	51,778	751	73,770	782	59,110
Special services	3,275	100,264	2,426	35,527	5,044	111,787	8,071	211,994
Total (any services)								
Total (all services)	45,196	18,286,748	45,856	19,128,760	47,406	21,378,644	45,575	22,573,372

TABLE 11. Maryland Medical Assistance Program: Payments (dollars) for Home Health Services, by Type of Service and Residence of Patient, Fiscal Year 1971. Note: There were no payments for Home Health Services to the residents of Calvert, Caroline, Charles, Frederick, and Worcester counties. (Source: Maryland Department of Health and Mental Hygiene, Center for Health Statistics, October 18, 1971.)

Residence of patient	Nursing service	Home health aide	Physical therapy	Occupational therapy	Speech therapy	Medical social service	Other	Medicare ded. and coins.	No Medicare B coverage	Total
Maryland State	97,737	9,899	6,344	496	53	450	5,161	22,979	7,370	150,489
Baltimore City	71,762	8,116	2,413			400	4,631	15,743	4,153	107,218
Total Counties	25,975	1,783	3,931	496	53	50	530	7,236	3,217	43,271
Allegany	4,295	22	130			50		591	56	5,144
Anne Arundel	880	115	1,198	409				850	5	3,457
Baltimore	4,866	12	1,244				93	1,541	699	8,455
Carroll	759	115						152		1,026
Cecil	858	154						460		1,472
Dorchester	140							288	281	709
Garrett	343						115	96		554
Harford	780		136					321		1,237
Howard	755						239	194	77	1,265
Kent	363							5		368
Montgomery	2,117		205					497		2,819
Prince George's	5,056	1,058	560	33	53		83	1,455	722	9,020
Queen Anne's								20		20
St. Mary's	36	66	432	54				127		715
Somerset	126									126
Talbot	-27							67		40
Washington	979	241	26					103	1,245	2,594
Wicomico	3,649							469	132	4,250

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because the charges per visit vary within the state from \$9.00 to \$14.00. Accordingly, the division furnished Table 12, which shows the number of visits for the majority of the certified agencies in fiscal year 1971. Seven of the 23 county health departments either were not certified agencies or reported no figures; 12 other counties reported 134 or fewer visits. It would appear, therefore, that home health care services financed through MAP either do not exist or are of little significance in 19 of the 23 counties.

TABLE 12. Reimbursable Medical Assistance Program Home Health Services, in fiscal 1971. (Source: Home health agencies' report of actual reimbursement.)

Agency	Nursing		Home health aide		Physical therapy		Other
	Visits	Dollars received	Visits	Dollars received	Visits	Dollars received	
Allegany	134	1,370.00			1	7.00	
Anne Arundel	(For all services, \$3,952.60 received for 425 visits full fee by MAP and deductibles for 753 plan B Medicare visit)						
Baltimore	25	400.00			75	1,200.00	
Calvert	(Not certified agency)						
Caroline	(Has never billed)						
Carroll	108	1,005.40	23	115.00			
Cecil	104	1,144.00	14	154.00			
Charles	(Not certified agency)						
Dorchester	19	266.00					
Frederick	(No figures available)						
Garrett	67				30	7.00	
Harford	105	780.00			8	127.00	
Howard	72	792.00					
Kent	60	660.00					
Montgomery							
Prince George's	(Was not billing Medicaid in that year)						
Queen Anne's	(None reported)						
St. Mary's	15	180.00	19	114.00	116	1,044.00	Occupational therapy 17=\$153.00
Somerset	33	198.00					
Talbot	17	108.90	8	64.00			
Washington	266	2,926.00	145	942.50	11	112.50	
Wicomico	872	5,232.00					
Worcester	(No home care program)						
Instructive Visiting Nurses Association	(Calendar Year 1970=\$95,581.00 for all services)						
Sinai Hospital	(Total received for Medicaid—\$9,514.82 for fiscal 1971)						22 patients full MAP fee; 8 patients partial MAP for deductible

Third-party Financing of Home Health Care Services: The limited extent of home health care services in Maryland is attributed in part to the restrictive conditions of Medicare, and its complex control system; to similar restrictions in Maryland's Medical Assistance Program; and to the fact that

such services are not covered under Blue Cross and Blue Shield. Indeed, for all practical purposes there is no third-party financing of long-term home health care. A chronically ill adult who cannot afford such services is inevitably forced into an institution unless he happens to be fortunate enough to be among the few who qualify for free care.

Medicare: In addition to certain time and procedural requirements, home health nursing benefits have in recent years been limited exclusively to skilled nursing services. Also, any care that appears to be "custodial" is not considered eligible for payment. Service agencies point out that frequently they will have provided care for several weeks or even months before being informed that the case is ineligible for Medicare benefits.

Two small counties have recently withdrawn from participation as a home health agency under Medicare. One of the county health departments explained:

Due to the increase in record keeping, duplication of records and record reviews being questioned, it was deemed necessary to take this action. The nurses are now requested to do patient care plans as well as comprehensive nursing narratives identifying physical, emotional, social, economic, and environmental needs of patients and their families. When supportive services, such as physical therapy, are also utilized for the same patient, the therapist is also requested to make the same type of plan and narrative in spite of the fact that this is duplication of effort by the health team members.

From May 1971 to May 1972, we billed the intermediary agency for home health agency patients for \$2,134.00. Our agency was paid \$798.20. The nursing assessment, care and supervision had been given, the required record keeping completed for all these patients. When one reviews these figures, economically it is not feasible to continue this service.

It is pointed out also that payments for services through Medicare do not accrue to the home care program. This reimbursement is paid into general state funds and the county health department is credited with the return which may be used for any type of health activity. Thus, Medicare funds provide no stimulus for expansion for home care services.

Medical Assistance Program: The limited extent to which MAP finances home health care services has been pointed out. One of the reasons, according to home health officials, is that MAP has not issued regulations governing payments. In their absence, agencies hesitate to assume responsibility for cases. Moreover, it was reported that MAP tends more and more to follow the lead of Medicare in refusing payment for cases regarded as "custodial."

Considering the potential of home health care for enabling sick and disabled adults to remain home, it would appear to be sound policy to liberalize MAP requirements in home care.

Blue Cross and Blue Shield: Home health care services are not covered under individual or group policies issued by Maryland Blue Cross and Blue Shield. Such provisions for persons under 65 have been under active consideration for several years.

The participation of Blue Cross—Blue Shield in home health care has been tried in Monroe County (Rochester) New York, where it has proved valuable. Also, the New York Legislature passed a statute which requires all group hospital insurance plans and certain other types of health policies to pay for home care services. While now limited to home care immediately following hospitalization, it may be a significant step in home care benefits under non-governmental health insurance plans in New York.

Summary and Conclusions: There are a few positive signs in home health care in Maryland: (1) the sustained interest and activity of the Division of Nursing of the Department of Health and Mental Hygiene in promoting home health services, including the establishment of a Home Care Coordinator; (2) new and vigorous professional leadership in the Baltimore IVNA; and (3) the mobilization of the active home care agencies in the Maryland Assembly of Home Health Agencies, which is currently being organized.

The major avenues through which home health care in Maryland may be strengthened to the point where living at home is a genuine alternative choice for a sick or disabled adult are the following:

- (1) Action by Congress to make preferential provisions for home health care services vis-a-vis institutional care mandatory in both Titles XVIII and XIX (Medicare and Medicaid);
- (2) Similar preferential provisions in the Maryland Medical Assistance Program;
- (3) Inclusion of home health care services in Blue Cross-Blue Shield policies;
- (4) A vigorous educational campaign by the medical societies to promote utilization of home care services by physicians in the state, as well as the extension of such services.

PART TWO: THE STATE PUBLIC ASSISTANCE PROGRAMS: SUPPORTIVE HOME SERVICES

"Public Assistance" programs are intended to provide aid to needy persons in their homes. The major differences are in quality and quantity, on the one hand, and "categorization" on the other. Thus the adult programs under consideration in this report represent an effort to provide "preferential assistance" to the aged, the blind, the permanently and totally disabled. These categories recognize their particular needs, which extend beyond basic living costs and include special grants and "social services."

Public assistance is the most important help available to needy elderly, disabled, and handicapped adults in their efforts to remain in their own homes. Whether the choice is real, however, depends upon the adequacy of the assistance granted and the kind of supportive services provided.

Standards of Adult Assistance in Maryland: The payment standards for basic living costs (food, clothing, and shelter) in Maryland in the three adult programs are inadequate by the State Social Services Administration's own standards. Thus, an elderly woman without income, living alone in rented quarters and furnishing her own light and heat, would be entitled to a maximum payment of \$96 a month, although the SSA has, in fiscal 1971, set a standard of \$128 per month for an adult in these circumstances. Maryland is among the four or five lowest states in the nation in its adult payment standard.

The choice of living on such a meager amount is an empty one. Such little money cannot be considered truly "supportive," and living in a group-care facility might actually be more desirable for the health and welfare of the person. Special allowances are available, however, to enable a needy person, under specified circumstances, to receive a grant to pay for care in his own home or in a private home setting.

Special Allowances to Provide Home Care: Because of their great potential for making the choice of home care a genuine one for a needy adult with some degree of disability, the provision for special allowances for services in the home are presented fully from the Manual of the State Department of Social Services (May 1972). These provisions are not widely known among the health and social-work personnel engaged in programs involving the elderly.

Following are the appropriate citations from the State Manual.

Intermediate and Domiciliary Care (Including Care in Own Home)

Skilled nursing care and intermediate care are provided under the Medical Assistance Program. An allowance for intermediate care, Level A (long-term care) or Level B (personal care), is made when there is medical substantiation of need for such care and when the eligible person receives such care in a private home not subject to licensing because it cares for only one person. An allowance also may be made for personal care or housekeeping services which enable a person to remain in his own home.

Intermediate Care, Level A, is that provided under medical supervision, needed because of physical or mental incapacitation, leaving the recipient unable to take care of his needs. Examples of patients needing this type of care would be a stroke patient who has reached maximum hospital and rehabilitation benefit, but continues to need bed care, perhaps incontinent care, etc.; a patient with a colostomy and unable to care for same, who may also need help in activities of daily living; a patient with Parkinson's disease with limited ambulation and in need of help with his activities or daily living. Patients in these facilities require a 24-hour plan of care developed by licensed personnel, but need only limited supervision, observation, or treatment by such staff. Most of their needs can be met by less qualified personnel.

Two hundred and ten dollars (\$210) is the maximum allowance for comparable care in a home caring for only one person, and therefore not subject to licensing. When there is this type of care in a home, giving such care to only one person, there is to be assurance that the situation is such that the patient would not be left alone and that

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the person giving the care can take responsibility for meeting such needs as: medication recommended by the physician, bathing, lifting, etc., even though there is no requirement that the person be a registered or licensed practical nurse, as would be true in the licensed home.

Intermediate Care, Level B, is that which provides shelter, board and personal services in a protective and safe environment, needed because of physical or mental incapacitation or advanced age. Examples of patients needing this type of care would be the elderly patient who is up and about, but is subject to nocturnal confusion and needs help in maintaining personal cleanliness, dressing, etc.; the blind patient who needs help in an institutional environment; the stroke patient who has recovered except for a mild aphasia and a mild residual weakness of the extremities.

One hundred and fifty dollars (\$150) monthly is the maximum allowance for comparable care in a home caring for only one person, and therefore, not subject to licensing. For the situation not requiring a license, there needs to be assurance that the person giving the care is available for personal services needed by the recipient and capable of meeting the particular needs. The patient may be receiving sustaining drugs and may require such help as with walking, eating, dressing, applying prosthetics or other activities of daily living.

Domiciliary Care is that provided to individuals who because of advanced age and physical or mental disability need personal surveillance or direction in the activities of daily living. Services include shelter, housekeeping services, board, in a protective and home-type environment.

The maximum allowance for this type of care in a licensed facility is set forth in Schedule J. The amount for which the individual is eligible is allowed by money payment. For comparable care in a home caring for three persons or less, and therefore not subject to licensing, the maximum allowance is \$110 monthly. For this type of care in a home that does not have to be licensed, there needs to be assurance that the patient would not be left alone and that the person giving the care can take responsibility for meeting the individual's particular need and for obtaining medical care as needed. When the home cares for more than one patient, there needs to be assurance that the needed services can be provided adequately to all. A facility may care for two domiciliary care patients and one intermediate care patient without being required to be licensed.

For Care in Own Home For housekeeping or personal services which enable a person to stay in his home, rather than having intermediate or domiciliary care outside his home, the allowance is the actual cost of such services up to \$80 monthly, in addition to other allowable items. The allowance can cover the cost of services or items necessary for the individual's safety, well-being and protection, which enable him to continue to live in his own home, rather than go into an intermediate or domiciliary care facility.

Utilization of Home Care Provisions: Statewide data on the extent to which home care payments are utilized could not be obtained. Figures were made available for Baltimore City, however. In July 1972, payments were made for intermediate care in private homes to 64 persons classified under Old Age Assistance (OAA) and to 66 classified as Aid to the Permanently Disabled (APTD). Figures were not available on the breakdown of these to the two levels of A and B with payments, respectively, of \$210 and \$150 per month.

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It must be emphasized that care in licensed intermediate care A and B homes is paid for under the Medical Assistance Program (Medicaid).

The \$110 grant for domiciliary care in a private home was made in 105 OAA cases and 102 APTD cases. In the same month only 40 OAA cases and 38 APTD cases were in licensed domiciliary care facilities, presumably at the allowable rate of \$210 per month. It is anticipated that these numbers will increase substantially with the growing utilization, particularly for patients leaving state mental hospitals, of University House in Baltimore with its capacity of 300.

Data on the extent to which the allowance for housekeeping or personal services is utilized is not available for the state as a whole. Table 13 shows for Baltimore City in the month of July 1972, by program, the number and percentage of cases receiving such an allowance, the total monthly expenditures for these extra allowances, and the average additional payment per case.

TABLE 13. Number and percent of adult cases in Baltimore City receiving additional funds in the assistance grant "For Housekeeping and Personal Services To Enable Them to Remain in Their Own Homes", funds expended for that purpose, and average expenditure per case (July 1972).

Program	Number of cases	Percent of caseload	Expenditure (dollars)	Average expenditure per case (dollars)*
Old Age Assistance	881	16.6	41,831	46.24
Aid to the permanently Disabled	1108	9.0	34,548	31.18
Public Assistance to the	59	26.5	3,474	58.88

*Calculated on the basis of June 1972 caseload.

It should be noted that a person whose income is sufficient to meet the payment standard for basic living costs (but no more) but who needs an allowance for "housekeeping or personal services" would be eligible for such a payment. It is not known, however, whether in practice such allowances are actually made under these circumstances.

Inclusion of Spouse in Grant: State policy also approves including money in the adult assistance grant for a needy spouse ineligible for aid under the adult categories, when the spouse is needed to enable the person to remain at home. The average monthly numbers of cases in which the spouse was included in the grant in fiscal year 1972 were as follows: Old Age Assistance, 348 cases; Aid to the Permanently and Totally Disabled, 691 cases; Public Assistance to the Needy Blind, 11 cases. The average amount of such additional payments for spouses included in grants could only be ascertained by a case-by-case analysis of the assistance budgets of each case involved.

Other Special Allowances: Grants for special diets, emergency grants for replacement of essential appliances and furniture, home renovation, and other special allowances are important, but a case-by-case analysis would be required to determine the extent to which such payments are currently being made.

Impact of the Social Security Amendments of 1972 on Supportive Home Services: On October 30, 1972, the President signed H.R. 1 (P.L. 92-603), an omnibus measure that provides for major changes in the Social Security Act. Amendments affecting Title II (Retirement and Disability Insurance), Title XVIII (Medicare), and Title XIX (Medicaid) as they relate to nursing home and home health care are discussed elsewhere. Pertinent here are the amendments establishing a new, national program of financial assistance to needy adults to be known as Supplementary Security Income for the Aged, Blind, and Disabled.

The essential provisions for this program have been summarized in the Washington Report of the American Public Welfare Association:

Supplemental Security Income for the Aged, Blind, and Disabled

Effective January 1, 1974, the present Titles I (Old-Age Assistance), X (Aid to the Blind), and XIV (Aid to the Disabled) are repealed, and Title XVI (combined categories) is replaced by a new Title XVI—Supplemental Security Income for the Aged, Blind, and Disabled. Until that time the existing programs will continue essentially unchanged.

The new Supplemental Security Income program will be administered by the Social Security Administration with full federal funding from the general revenue for the basic benefits. Uniform national standards are established. Aged, blind or disabled persons with no other income (and with limited resources) will be eligible to receive a monthly payment of \$130 for an individual or \$195 for a couple. The first \$20 of any income (including social security benefits) will be disregarded in determining need, as well as the first \$65 plus one half above that of earned income. Thus, aged, blind, or disabled persons having an income of \$20 from social security or other sources will receive an income of no less than \$150 for an individual or \$215 for a couple.

Eligible individuals who are in a hospital or nursing home and receiving Medicaid assistance will be eligible for payments of up to \$25 a month in lieu of their regular benefits.

Anyone receiving or who would be eligible upon application to receive benefits under this program will not be eligible to receive food stamps or surplus commodities. A state, however, could elect to supplement the federal payment from state or local funds, with no federal matching.⁵

The new program, with more generous payment standards than those in Maryland, will make an important contribution to the lives and circumstances of needy adults. The monthly sum of \$130 will replace payments of \$96 and \$92, depending upon where the beneficiary resides. A more generous attitude by Social Security toward earned income will result in a greater net increase for many individuals.

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The new federal payment standard of \$130 a month, however, should not be viewed as other than a more reasonable sum to cover basic living costs. In 1971, the "full standard" of the State Social Services Administration for basic living costs (rent, utilities, food, and clothing) of an elderly woman living alone in rented quarters and paying for heat and light was \$128 a month. With the increases in living costs occurring in the meantime, the federal standard of \$130 for 1974 will be at the state agency's subsistence level, or slightly below.

Despite the generosity the federal payments reflect compared with Maryland's basic provision for needy adults, these benefits will be just what the new title indicates: *supplemental security income*. There is no provision for special grants such as those that enable persons to remain in their own homes, for special diets, and certain emergencies.

Thus the present provisions in the public assistance program which make it possible for many elderly, handicapped, and disabled adults to remain in their own homes or in a private home setting will not be available through the federal program which will take over basic assistance costs for needy adults on January 1, 1974.

Figures cited above furnish a clue to a reasonable estimate. It may be assumed that the majority of those receiving the \$110 monthly payment for domiciliary care in a home setting would be able to finance this from the federal benefit. On the other hand, it may be assumed that all of those receiving an intermediate care grant of either \$150 or \$210 a month would not be able to pay this sum in full from their federal benefit. It may be assumed that the majority of those receiving the housekeeping grant over and above the allowance for basic needs would not be able to pay the full costs of housekeeping services from the federal benefit. Table 14 brings together the available figures on the numbers receiving supportive home care currently who might need a supplement to the federal grant if they are to remain in a private home setting.

TABLE 14. Persons receiving supportive home care who might need a supplement to the federal grant.

Type of Care	Old Age Assistance	Aid to the Permanently Disabled	Public Assistance to the Needy Blind
Intermediate (Baltimore City only)	64	68	2
Housekeeping grant (Baltimore City only)	881	1108	59
Spouses (state figure)	348	691	11
Total	1293	1867	72

About 45 percent of the total state OAA caseload is found in the counties, and slightly over a third of the APTD caseload. *Thus it may reasonably be estimated that more than 4,000 elderly and disabled adults may lose the financial support that enables them to live in their own homes or a private home when the federal program of Supplemental Security Income goes into effect January 1, 1974, unless legislative action is taken to continue supportive home services.*

Foster Family Care for Adults. The first publicly financed foster-home program for the elderly in Maryland was launched by the Baltimore County Department of Social Services in 1972. The purpose of the program was set forth in the prospectus:

Foster family care for the aged and physically handicapped adult is a service to adults who need, desire, and are capable of, social care in a family setting. A family-care home is intended for use by the older individual who is functioning too well to be sent to a nursing-home facility, but who is not capable of complete independence and thus continues to need a moderately supervised environment. The preventive aspect of this service is emphasized; however, it may also be seen as rehabilitative, when it may offer a revival of the older person's dormant capacity for human relationships, thus once again giving content and meaning to his existence by the support and security of family living. Foster-family care programs for aged already established in other states have produced the finding that there is clear indication of positive growth, in the foster-adult, from a dependent, inactive status to one of responsibility, independence, and a new-found direction in life.

The foster family is paid \$150 a month to provide a home for the adult. To be eligible, the "adopting family" must have some other income than this payment. Except in special circumstances, the family must have a private room for the individual. To be eligible, the elderly person must be able to pay for his own medical needs directly or through participation in the Medical Assistance Program.

Homemaker Service for Adults: The primary objective of homemaker service for adults is to enable aged, disabled, and chronically ill persons to remain in their own homes and avoid nursing homes and institutions. A secondary objective is to provide auxiliary services to enable individuals and families to obtain medical, nursing and dental care, food, and other essentials necessary for improved health, safety, and independent living.

Homemaker service is currently being provided to eligible families with children, the aged, blind, disabled, and chronically ill adults who are recipients of public assistance grants or who receive medical assistance only. Services are provided by the Baltimore City Department and 19 of the county departments of social services. Figures on adult services are shown for the counties and Baltimore City as of September 1972 in Table 15.

The budget for homemaker services during fiscal year 1973 is \$2,057,026, which authorizes 343 positions for local departments. Forty-one of these

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TABLE 15. Persons receiving homemaker services during September 1972.

Local department	Total No. (PA and MA only)	Characteristics of recipients		
		Age 65+	Blind (No.)	Disabled (No.)
Allegany	38	24		14
Anne Arundel	44	34	2	8
Baltimore	7	4		2
Calvert	29	14		15
Caroline	10	1		9
Carroll	27	19		8
Cecil	15	9		6
Charles	36	12	3	21
Dorchester	13	10	1	2
Frederick	30	16		14
Garrett	2			2
Harford	22	14		8
Howard				
Kent				
Montgomery	41	31		10
Prince George's	58	36	2	20
Queen Anne's				
St. Mary's	68	34	1	33
Somerset				
Talbot				
Washington	11	9	0	2
Wicomico	13	9		4
Worcester*				
Total Counties	464	277	9	178
Baltimore City	127	99	5	23
State	591	376	14	201

*Homemaker employed December 1972

positions were frozen during fiscal year 1972 and, in December 1972, still had not been released.

Services to the elderly and disabled have expanded considerably during the last three years, services to adults having been initiated in fiscal year 1970. Comparisons of numbers of persons served in November 1970, November 1971, and September 1972 are given in Table 16.

TABLE 16. Number of elderly and disabled persons served, 1970 through 1972.

Department	November 1970	November 1971	September 1972*
County	10	188	464
Baltimore City		28	127
Total	10	216	591

*The figure of 591 adults served compares favorably with the number of families (715) served in September 1972.

Summary and Conclusions: The low payment standard of \$96 a month for basic living costs for a needy adult living alone does not provide a genuine choice as an alternative to institutional care.

Special allowances are available under certain circumstances which have a great potential for making the choice of home care a genuine one, even for an adult with some degree of disability.

These special allowances include payments for two levels of intermediate care and domiciliary care in a private-home setting; for housekeeping or personal services; for inclusion of the needs of the spouse in the grant; for special diets; for certain emergencies.

The Social Security Amendments of 1972 provide for federal take-over of the three adult programs on January 1, 1974, in a program to be known as Supplemental Insurance Income. Its benefit payment standard of \$130 a month for a needy adult represents a significant advance over Maryland's present \$96.

There is no provision for special allowances such as those currently in effect in Maryland to enable disabled adults to remain in home settings such as the intermediate care, housekeeping, special diet grants, and the inclusion of the needs of a spouse in the payment.

Unless the Maryland General Assembly acts to continue these special allowances, it is estimated that 4,000 elderly and disabled adults in Maryland will lose the financial support that enables them to live in their own homes or in a private home.

Only minimal progress has been made in Maryland in providing social services to adults receiving public assistance, former recipients, and potential recipients for which the federal government furnishes 75 percent of the cost.

Protective services for adults are non-existent in the state.

Only one county operates a foster-home program for adults and that is of recent origin.

Homemaker service for adults did not become available until 1970. While still limited, homemaker service, relatively speaking, has increased substantially.

The Revenue Sharing Act of 1972 limits federal participation in only 10 percent of the costs of social services to persons not currently receiving or applying for public assistance grants. This limitation will cause a cutback in the homemaker program and offers no financial incentive for the state to expand other services to adults.

Supportive Home Services

References

1. *Home Health Services in the United States*. Report to the Special Committee on Aging, U.S. Senate (April 1972); pp. 59-60.
2. A certified home health agency is one that is judged by the State Department of Health and Mental Hygiene to provide safe and high quality health care services.
3. See, for example, U.S. Senate, Special Committee on Aging, Subcommittee on Health of the Elderly, *Cutbacks in Medicare and Medicaid Coverage*. (Washington, D.C.: Government Printing Office, 1972), Part 3.
4. It should be noted that the \$96 figure is applicable only to Baltimore City and Allegany, Anne Arundel, Baltimore, Cecil, Montgomery, and Prince George's Counties. Elsewhere in the state the payment standard is only \$92.
5. *APWA Washington Report* 7,1 (November 3, 1972).

*This report was prepared for the Commission by Robert T. Lansdale.
January 10, 1973*

4:

An Analysis of Community Services Available to the Elderly

This report is a sketch of the services available to the elderly in Maryland. It is an effort to bring to light, from documented data, information which may help the planning and implementation of a statewide comprehensive program for our senior citizens.

The information provided in this report is based on 116 questionnaires which were forwarded to various agencies throughout the state (questionnaire attached). Among those responding were 20 educational institutions, 29 private agencies, 7 commissions on aging, 25 health departments, 9 Red Cross chapters, 8 community action agencies, 3 departments of social services, 9 cooperative extension services and others. Additional questionnaires received after the deadline were not included.

The agencies listed above may be truly representative of services available to the elderly in Maryland. They should not be considered a complete list of available services. The value of the information presented here is that it makes clear that these agencies share problems and concerns of most, if not all, agencies providing services to the elderly.

Analysis of the Questionnaires: The questions selected for this analysis were 5, 6, 7, 9, 10, 12 and 13. The data is presented from three perspectives: statewide; geographical area; and agency.

STATEWIDE PERSPECTIVE

A. *What are the Approximate Number of People Served by the Program in an Average Month?* Sixteen of the 116 responding agencies reported no services to the elderly; 48 provided services to more than 161 persons monthly; 14 served between 0-20; and 15 agencies between 41-60, leaving the other agencies scattered among the other ranges.

B. *What is the approximate percentage of those 65 and over served by the program (in relation to the total population served)?* Of the agencies serving the elderly, a significantly greater number, in relation to their total

population served, within the range of 0-20 percent with the number of elderly served decreasing indirectly as their percentage served, within a particular agency, increased.

C. What services are provided?

<u>Type of Service Provided</u>	<u>Number of agencies offering services</u>
Senior center	23
Civil influence and action	17
Outreach and referral	41
Home health aide service	22
Other health services	37
Homemaker services	19
Housing assistance	17
Home repair services	9
Handyman services	3
Transportation assistance	35
Legal services	8
Employment training or job finding	19
Consumer education	28
Other education	35
Credit unions or buying clubs	4
Feeding programs	7
Home-delivered meals	7
Congregate meals	6
Other meals	4
Recreation and/or social activities	32
Handicrafts	30
Friendly visiting service	20
Telephone reassurance	28
Other	25
None	16

It might be interesting to note some of the services provided under the heading of "Other Health Services" by health departments: Public health nursing, home visiting, counseling, referral, physical therapy, speech therapy, level-of-care determinations, quality-of-care determinations, environmental inspections, pre-admission screening and evaluation, X-ray, cardiac, arthritis, alcoholism, mental health and neurology clinics, coordinated discharge program with certain hospitals, and nutrition services.

Additional services offered to senior citizens in various areas of the state (specified as "Other Services" in the questionnaire): Food stamps, rehabilitation after disaster services, counseling, low income assistance, organization or

Community Services

senior citizens groups, survey of senior citizen needs, leadership training, newsletter, emergency clothing, emergency food, discount program, tax assistance.

Eligibility requirements were computed as follows:

	<u>Number of agencies with requirements</u>
Income	16
Geographic location	36
Age	27
Sex	1
Race	—
Religion	2
Other	18
No requirement	35

Answers to the question of fees charged to those using the service:

<u>Type of fee</u>	<u>Number of agencies with fee</u>
Sliding scale	19
Flat fee	8
Other	15
No fee	68

<u>Type of Funding</u>	<u>Number of Agencies with Specific Types of Funding</u>
Federal	47
State	48
Local government	53
Third-party funding	14
Contributions	32
Other	19

The majority of the agencies claimed to maintain liaison and connections with all agencies, while others alluded to specific agencies or institutions such as hospitals, departments of social services, nursing homes, health departments, commissions on aging, community action agencies, informal contacts, private organizations, and voluntary organizations.

There were numerous problems, limitations, and restrictions which the agencies face in delivering services. The following chart gives a general view of the problem areas:

Community and Long-Term Care

Problems Experienced by Agencies (in rank order)

	<u>Number of Agencies</u>
Funding	44
Lack of trained and experienced personnel	31
Transportation	24
Inadequate policies	16
Homemaker services	15
Insufficient and inadequate alternatives to home living	13
Protective services	8
Communication	6
Health services	6
Housing	5
Employment	1
Lack of congregate eating facilities	1

Other Problems:

- (1) Lack of county government support for planning and coordinating services which results in duplication.
- (2) Competition among agencies for funds and lack of identification of unmet needs of senior citizens.
- (3) Reluctance of elderly to accept social services.
- (4) Gaps in services which no agency has been set up to meet.
- (5) Lack of mechanism for providing and insuring continuity of care.
- (6) Problems of young prevent additional services from being implemented for the older population.
- (7) Lack of Space.
- (8) Lack of elderly participation.
- (9) Underutilization of home health services.
- (10) Absence of meaningful liaison with Commission on Aging.
- (11) Apathy among state and local officials.
- (12) Lack of volunteer involvement.

Why is it that there were not more responses? Is it that agencies which did not respond provide no services to the elderly? Or so few services that they were not worth mentioning? Since they did not take the time to fill out the questionnaires, does this say something about what they feel is important, or not important?

Geographical Perspective

There are six geographical areas made up of Baltimore City and the 23 counties (as defined by the Regional Planning Council of Maryland) (See Tables 1 and 2):

Upper Eastern Shore: Cecil, Kent, Queen Anne's, Talbot and Caroline counties.

Lower Eastern Shore: Dorchester, Wicomico, Worcester and Somerset counties.

Southern Maryland: Calvert, Charles and St. Mary's counties.

Maryland-National Capital Area: Montgomery and Prince George's counties.

Western Maryland: Allegany, Frederick, Garrett and Washington Counties.

Baltimore Metropolitan: Baltimore City and Anne Arundel, Carroll, Harford, Howard and Baltimore counties.

TABLE 1. Services provided by agencies in the six geographical areas.

Service	Eastern Shore		Western Maryland	Baltimore Metropolitan	National Capital	Southern
	Lower	Upper				
Senior center	1	1	4	12	3	2
Civic influence and action	1	0	3	11	2	0
Outreach and referral	7	3	9	15	5	2
Home health aides	2	5	2	9	3	1
Other health services	5	7	6	12	5	1
Homemaker	4	1	1	6	3	3
Housing assistance	1	2	4	6	2	2
Home repair	0	1	2	4	1	1
Handyman	0	0	0	3	0	0
Transportation assistance	6	3	10	9	6	1
Legal	0	1	1	4	1	1
Employment training and job finding	1	1	4	10	2	1
Consumer education	2	3	2	12	5	4
Other education	2	3	6	14	6	3
Credit unions or buying clubs	0	0	1	3	0	0
Feeding programs	0	0	2	2	2	1
Home-delivered meals	0	0	1	4	2	0
Other meals	0	0	1	4	1	0
Recreation and/or social activities	0	0	0	3	0	1
Handicrafts	1	2	5	16	4	4
Friendly visiting	1	0	5	16	3	5
Telephone reassurance	4	2	5	12	4	1
Other	5	3	1	12	4	0
Number of agencies responding	17	14	19	39	15	7

Community and Long-Term Care

TABLE 2. Problems experienced by agencies in the six geographical areas.

Problem	Eastern Shore		Western Maryland	Baltimore Metropolitan	National Capital	Southern
	Lower	Upper				
Funding	7	4	7	16	9	1
Lack of trained and experienced personnel	2	5	4	11	7	2
Policy inadequacies	1	0	3	9	3	0
Employment	0	0	0	1	0	0
Transportation	2	4	5	8	3	2
Communication	1	0	0	3	1	1
Protective services	3	1	0	3	1	0
Insufficient, inadequ- ate alternatives to home living	0	4	2	4	2	1
Housing	1	1	2	1	0	0
Lack of central eating facilities	0	0	1	0	0	0
Health services	1	1	1	2	1	0
Homemaker services	2	3	2	6	2	0
Others	2	4	5	7	2	2
None	3	0	0	0	0	0
Number of agencies responding	17	14	19	39	15	7

AGENCY PERSPECTIVE

The focus in this section is on the agency. The data will provide us with an idea of the types of services offered by certain agencies, as well as the problems encountered in delivering these services (Tables 3 and 4).

TABLE 3. Services provided by agencies.

Services	Education institution	Local commission on aging	Health department	Bureau of recreation and parks	Private agencies	Red Cross	Community action agencies	Department of social services	Extension services
Senior center	1	4	0	2	13	1	2	0	0
Civic influence and action	1	3	2	1	5	1	2	0	1
Outreach and referral	1	5	5	0	16	4	6	2	2
Home health aides	0	2	14	0	4	0	1	0	1
Other health services	0	0	22	0	8	2	4	2	0
Homemaker	4	0	3	1	5	1	2	2	1
Housing assistance	1	2	1	0	5	0	5	2	1
Home repair	2	1	0	0	4	0	1	1	0
Handyman	0	0	0	0	1	0	0	0	2
Transportation assistance	1	3	6	0	12	2	7	2	1
Legal assistance	1	2	0	0	1	0	3	1	0
Legal services	1	2	0	0	1	0	3	1	0
Employment training and job finding	2	4	0	0	0	1	6	0	0
Consumer education	7	3	2	0	4	1	3	0	8
Other education	11	6	2	0	6	3	1	0	6
Credit unions or buying clubs	0	1	0	0	0	0	3	0	0
Feeding programs	0	0	0	0	4	0	2	0	1
Home-delivered meals	0	1	0	0	5	0	1	0	0
Congregate meals	0	1	0	0	3	1	1	0	0
Other meals	0	0	0	0	2	0	0	1	0
Recreation and/or social activities	3	4	1	3	14	2	4	0	2
Handicrafts	3	2	0	3	11	2	4	0	5
Friendly visiting	1	3	1	1	8	2	3	1	1
Telephone reassurance	2	5	5	1	10	1	2	0	2
Other	2	2	2	2	11	4	2	1	2

TABLE 4. Problems encountered by agencies in delivering services.

Problem	Educational institution	Local commission on aging	Health department	Bureau of recreation and parks	Private agencies	Red Cross	Community action agencies	Department of social services	Extension services
Funding	2	6	9	0	15	3	4	3	2
Lack of trained and experienced personnel	2	2	11	0	10	3	0	0	3
Policy inadequacies	1	0	8	0	6	0	3	0	0
Employment	0	0	0	0	1	0	0	0	0
Transportation	4	1	2	0	12	0	2	1	2
Communication	1	0	2	0	3	0	0	0	0
Protective services	0	0	2	0	2	0	0	0	2
Insufficient, inadequate alternatives to home living	0	1	5	0	5	0	0	0	0
Housing	0	0	1	0	2	0	0	2	0
Lack of central eating facilities	0	0	1	0	0	0	0	0	0
Health facilities	0	0	1	0	3	0	1	1	0
Homemaker services	1	0	6	0	5	0	1	1	1
Others	2	3	5	1	5	1	1	1	3
None	2	0	0	2	0	3	0	0	2

Community Services

TABLE 5. Source of funds.

Service	Federal	State	Local	Third-party	Contributions	Other
Senior center	9	6	10	3	10	5
Civic influence and action	0	6	10	3	10	3
Outreach and referral	24	17	22	4	15	5
Home health aides	8	15	14	7	2	5
Other health services	19	28	23	8	4	5
Homemaker	10	11	9	3	6	5
Housing assistance	13	8	11	1	7	1
Home repair	7	4	4	2	2	3
Handyman	2	1	0	1	2	0
Transportation assistance	19	14	20	7	14	8
Legal	6	3	4	0	1	1
Employment training or job finding	14	10	11	0	7	0
Consumer education	21	17	18	2	6	3
Other education	20	16	20	3	10	6
Credit unions or buying clubs	4	1	3	0	1	0
Feeding programs	6	2	2	1	3	2
Home-delivered meals	4	2	2	1	4	3
Congregate meals	4	3	3	1	3	1
Other meals	4	2	2	0	2	0
Recreation and/or social activities	15	7	18	6	16	9
Handicrafts	16	11	17	3	12	5
Friendly visiting	11	9	12	2	11	4
Telephone reassurance	14	14	16	3	12	3
Other	14	14	9	2	12	4

TABLE 6. Programs or agencies with eligibility requirements.

With requirement	People (No.)							
	0-20	21-40	41-60	61-80	81-100	101-120	141-160	161+
Income	1	2	0	2	0	0	1	10
Geographic location	4	7	4	0	3	0	1	17
Age	2	3	1	3	2	0	1	17
Sex	0	0	0	0	0	0	0	0
Race	0	0	0	0	0	0	0	0
Religion	0	0	0	0	0	0	0	2
Other	5	4	2	0	0	0	0	7
None	5	5	2	4	1	1	1	16

Community and Long-Term Care

TABLE 7. Programs or agencies without eligibility requirements.

Without requirement	People (No.)							
	0-20	21-40	41-60	61-80	81-100	101-120	141-160	161+
Income	13	13	8	5	4	1	2	38
Geographic location	10	8	4	7	1	1	2	31
Age	12	12	7	4	2	1	2	31
Sex	14	15	8	7	4	1	3	47
Race	14	15	8	7	4	1	3	48
Religion	14	15	8	7	4	1	3	46
Other	9	11	6	7	4	1	3	41
None	9	10	6	3	3	0	2	32

This report was prepared for the Commission by Bernadette Green.

D:

Institutions and Long-Term Care

The word institution has a variety of implications and meanings today, most of them disparaging. One hears, for example, that someone has been *institutionalized*. The image is of someone being carried off to a mental hospital in a straight jacket. Newspapers are filled with reports of outrageous conditions present in our penal *institutions* raising the spector of tiny cells with bare walls in which residents dangerous to society are placed. News commentators often refer to the recalcitrance of major governmental *institutions*, inferring that these large bureaucratic bodies are immune to winds of change and are filled with individuals somewhat calcified by time.

In this section of the report, the Commission has attempted to take an unbiased look at those institutions which serve Maryland's aged and chronically ill citizens. Crucial to an understanding of this area is the awareness that the aged and chronically ill utilize the same facilities as the general population. Thus, we have included a wide range of institutions spanning the spectrum from general hospital to intermediate care B nursing facility. While the Commission does not hesitate to criticize these institutions and demand immediate improvement, the specific intent is to seek improved methods of utilizing programs and services currently available. It is not the intent, for example, to try and turn around the profit-making nursing-home system. Rather, it has sought to discover what problems exist in this system and how the public agencies can work in conjunction with the private sector to improve the care being provided.

Upon completion of this section, the reader should have a comprehensive picture of the institutional system for the aged and chronically ill in Maryland as well as a good indication of where the gaps exist, what improvements are required, and to what extent people are being ill-served by current procedures and policies.

1:

Long-Term Care Ombudsman Program: A Proposal

DESCRIPTION AND SCOPE OF PROJECT

Purpose

During the past ten years, this nation has witnessed a series of encounters involving the long term care industry on one side and a variety of National, State and Local organizations on the other. In the great majority of instances, these encounters have resulted from crises wherein residents within the facilities have been the victims or alleged victims of major disasters ranging from fires to Salmonellosis.

The traditional method for dealing in a post-crisis manner with these problems has been to appoint an investigatory body (Ralph Nader, Congressman Pryor, Maryland Commission on Nursing Homes) which conducts an in-depth analysis of the event and produces a report replete with recommendations for future avoidance of similar events. While these investigatory bodies have proved of considerable value in the establishment of more stringent procedures and industry guidelines, it can be argued that they have to a great extent not met the need for an ongoing monitoring procedure.

The guidelines and procedures mentioned above are monitored through the traditional mechanism of "inspectors" or surveyors armed with massive "normative" forms against which conditions within a facility are "thrown" in order to measure lack of—or conformance to—existing requirements. We would posit that this type of regulatory program is extremely useful in identifying major and glaring deficiencies, but does not begin to focus upon and deal in any systematic way with the actual or perceived problems of patients and/or their families.

The experience of the Maryland Governor's Commission on Nursing Homes provides considerable substantiating evidence to our thesis that existing inspection procedures fail to meet the needs of patients within facilities. Although this Commission was appointed as a blue ribbon/limited-

life investigatory and recommendation body, it rapidly became a repository for complaints from both patients and patient families. In effect the public was either unaware of existing units within the state Departments of Health and Social Services, or were sophisticated enough to realize that these units were not "tooled up" to handle these types of complaints and problems. During conversations with those individuals calling the Commission, the staff received statements which reflected the need for an independent operation to handle specific patient needs and complaints:

I can't go to the administrator (of the facility) he will take it out on my mother.

Those inspectors (State Surveyors) only see what the Home wants them to see.

Those nurses (employees of health departments) only see the big things, never have time to talk to my mother.

The Home told me to call Social Security or get a lawyer.

The resultant effects of conversations such as those described above was that the Governor's Commission, unable by virtue of its mandate, restricted inspection powers, and limited staff to deal with the complaints, passed them on to the very agencies which the public perceived as inappropriate or impotent. (We must make clear that this narrative is not intended to denigrate existing agencies, but rather to demonstrate the need for a different and unique body capable of dealing quickly and efficiently with specific patient-based complaints).

Prior to any discussion of the proposed program, it is important to mention the lack of authority and clout held by residents within long term care facilities. It is this lack of muscle which creates the requirement for an advocacy body such as the one described below. By the very use of the terms skilled nursing, extended care or long term care, it is anticipated that the majority (estimated 70%) of the residents within these facilities have a debilitating or disabling condition which severely limits the amount of energy which they are able to devote to self-advocacy causes. In addition to the health related weaknesses of the residents, there is a psychological/social happening which occurs that is perhaps even more energy sapping than physical frailties. For purposes of this description we shall refer to this condition as "institutionalization." When this process takes place in a nursing home or other long-term care facility, it is far more injurious than a similar occurrence within a general (acute) hospital. This is due in large part to the widely held and altogether accurate perception of the nursing home as a one-way door (in) while an acute hospital is seen as a limited-stay facility.

Once settled into a long term care facility, the institutionalization process brings about feelings of anomie, abandonment, loneliness, uselessness, impotency, and a variety of other behavior manifestations all of which contribute to the need for a patient spokesman. The need is equally critical for those residents who comprise the 25% inappropriately placed within the

facility. For although their physical capacities are far greater than the majority of their fellow patients, the institutionalization process wreaks equal havoc upon their psyche. It is the equivalent of being a prisoner who deserves release but for whom no prisoner advocate or halfway house exists.

The families of patients are not immune from this lack of authority or ability to influence decisions. For many, the fear of retribution focused upon the relative in the facility prohibits their acting in an advocacy capacity. For others, their own advanced age or physical limitations act as a barrier to effective action. For the remainder, an ignorance of the procedures necessary to navigate the complex systems with which they are dealing effectively closes off all paths which might lead to amelioration of the problem.

Wherein lies the problem? Why aren't the personnel and agencies on the scene able to effectively deal with patient and family problems? If one takes a brief look at the people and agencies involved, the answer rapidly becomes apparent. The unskilled and para-professional staff within facilities suffer a great variety of depersonalizing actions which render them unable to provide an advocacy role. They are (in general terms) underpaid, overworked, without ego-building supports, untrained and non-certified. The great majority of their energy is spent keeping up with these demands and they have little time or stomach for advocacy activities.

The skilled nursing and medical staff spend much of their time dealing with daily crises which arise, of a medical nature, maintaining records required for the numerous programs with which they are involved including Medicare, Medicaid, third-party insurers, civil rights compliance, and so on. In addition they are responsible for overseeing the tasks performed by the nonskilled personnel described above. To expect the skilled medical service to provide an Ombudsman-like service would be to dilute those efforts aimed at avoiding the very problems which require the advocate program.

While the administrator or owner or both of the facility may at first blush appear to be the most logical point in the system to whom the patient or family might turn for relief, it must be kept in mind that organizational survival is a continuous and time-consuming task. It is simply unrealistic to assume that the person(s) most directly liable for the care rendered and services provided, would be willing to spend time on critical self-analysis of the facility. Indeed the society would be ill-served if the administrator devoted his time to individual patient complaints while allowing the general operations of the facility to go untended.

As was mentioned earlier, the licensing and enforcement units of the Health Department and the Department of Social Services were never intended to provide the personalized complaint mechanisms envisaged in this program. Indeed it can be argued that the monitoring of the entire operation for licensing and enforcement purposes is so large and so critical that a

weakening of these efforts to deal with individual complaints would be a disservice to the state and its residents.

The preceeding pages provide an overview of the current long term care/patient problems situation in Maryland. It demonstrates an overwhelming need for an office which will, in fact, represent the interests of the patients, patient families and health care personnel. We are dealing with a fairly large proportion of the state's elderly population. While some 5 percent of the over 65 group may not appear large in actual numbers, the society cannot ignore its responsibility to some 15,000 older adults.

As there is a rather large percentage of proprietary facilities within the state, a question might be raised as to the "right" of the state to interfere in the "operations" of such facilities; however, large amounts of public monies are being utilized in these facilities. It is our position that accountability to the public for the proper utilization of these funds (Medicare, Medicaid, public assistance, Social Security, other pensions), provides the necessary "auspices" under which this program can be provided.

The following program description provided under the heading "Approach" spells out in detail the various component parts which must be linked in order to ensure a comprehensive approach to the problem.

Approach

The "Long Term Care Ombudsman" program would be a public, non-profit corporation with linkages to non-profit health and social service agencies, the official city agency serving the aged and chronically ill, the official state agency serving the aged, a statewide medical group, a public legal services agency and the federal government.

1. United Fund of Central Maryland

As currently perceived, the United Fund of Central Maryland could serve as a *partial* coordinating and sponsoring body for the Ombudsman program. As United Fund continues its efforts to reach out to the community and involve itself in innovative programs serving a population group in need, the Ombudsman project appears to uniquely fit its objectives. United Fund would assist in its development through: 1) the use of its "good offices" to aid in the coordination of various social agencies involved in the program; 2) the use of its excellent public relations network to publicize the program and thus educate potential users; and 3) assistance in locating partial funding monies aimed at establishing the program.

2. Health and Welfare Council of the Baltimore Area, Inc.

The Health and Welfare Council could operate in a manner similar to that of United Fund with one major exception. The Council currently operates an Information and Referral Service for the Aged under a partial (1/3) grant from the State Commission on Aging. The Information and Referral Service

would be a major linkage through which calls (complaints) could be referred to the Ombudsman office. While the Ombudsman Office would not be under the auspices of the Health and Welfare Council, the education of the public component in conjunction with the use of the I and R service as a referral source will significantly strengthen the Ombudsman Office. (This assumes continuance of this I and R service).

3. Baltimore City Commission on Aging and Retirement Education

The recently reorganized City Commission on Aging could serve as the major focal point for the Ombudsman Office. The reasons for this choice are multiple: 1) the Commission has a high degree of autonomy given the placement within the Mayor's Cabinet of the Executive Director; 2) the composition of the Commission membership ensures that a high degree of consumer input would be available; 3) the proposed linkage with the Waxter Center (a multi-purpose Senior Center) is evidence of the Commission's concern in this area; 4) the Commission is the "single" agency which speaks for the aged in the City and the aged (over 65) population of Baltimore represents the largest enclave of senior citizens in the State; and, 5) the expertise within the Commission will allow for immediate and effective utilization of the Ombudsman service.

4. Maryland Medical and Chirurgical Faculty

The Med-Chi Faculty would serve to "legitimate" the Ombudsman Office within the medical profession serving long term care facilities. The understanding and cooperation of physicians in the long term care field is crucial to the success of this program. Med-Chi would act in an educative capacity for both physicians and the user of the service. It would also aid in the general effort to make the public aware of the existence of the program and could aid in cutting down prior resistance on the part of nursing home physicians or Administrators/Owners.

5. Legal Aid Bureau Inc.

There will be a variety of patient related problems which are not amenable to administrative solution. In those cases requiring legal advice and/or action (such as patient monies) the Legal Aid Bureau will serve in a consultant capacity. The Bureau has recently moved into the aging arena and will provide much needed input into the Ombudsman program.

As the program is currently envisaged, the Ombudsman office will be a public, non-profit agency funded by private foundation monies. (It will be organized along lines similar to those followed by Ralph Nader's organization.) It could operate as an independent agency with a Board of Directors comprised of professionals with a high degree of expertise and interest in the aging and long-term-care field.

The Ombudsman office would be composed of a *Director, Deputy Director, Administrative Assistant (intake coordinator) and Executive*

Secretary/Accountant, in addition to the Board of Directors. The Director and Deputy Director of the Ombudsman office will be appointed (hired) by the Board of Directors. The remainder of the staff will be hired by the Director of the Ombudsman office.

The Ombudsman office will serve the *Greater Baltimore Metropolitan Area*, consisting of *Baltimore City and Baltimore, Anne Arundel, Carroll, Harford and Howard Counties*. This area has been selected due to the high number of nursing homes, nursing-home beds, and over-65 population. At the end of a three-year period, the program will be closely examined to determine the feasibility of expanding it to a statewide program.

In addition to the staff of the Ombudsman office (full-time, salaried professionals), there could be a *cadre of trained volunteers* drawn from the following organizations: 1) *Junior League*; 2) *Retired Senior Volunteer Program*; 3) *Junior Chamber of Commerce*; 4) *Catholic Charities*; 5) *Associated Jewish Charities*; 6) *County Commissions on Aging*; 7) *Midtown Churches Association*; and 8) other similar agencies. These volunteers could be trained by Masters Degree in Social Work students (clinical and administration sequences) under the supervision of professional (MSW) faculty members from the School of Social Work and Community Planning of the University of Maryland.

Program Operation

Step One—The intake coordinator receives the complaint from the following sources: a) phone call (central, toll free exchange); b) letter; c) referral from other agencies; d) information and referral service.

Step Two—All information is transcribed onto "Initial Intake Form." The forms are then reviewed twice daily by the professional staff of the Office to ensure accuracy and comprehensiveness.

Step Three—The information received is subjected to initial verification through contacts with: a) other family members; b) friends; c) state and local agencies (to pick up previous complaints).

Step Four—The volunteer(s) covering a certain geographic area would then be given a copy of the intake report in addition to any verification or clarification reports gathered by the staff. A discussion of the specific cases between the staff and the volunteer would take place prior to the volunteer visiting the facility.

Step Five—The volunteer would visit the patient in the facility and gather all information pertinent to the problem. Subsequent to this interview, the volunteer would discuss the problem with the director of nursing, administrator of the facility and/or the owner of the facility. All of this information would be transcribed onto "nursing home interview form."

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Step Six—The volunteer in conjunction with the deputy director would seek to remove or ameliorate the problem through a joint meeting with the administrator, nursing home personnel, patient and family or friend.

Step Seven—If the situation were corrected to the satisfaction of all involved, the statistics would be entered onto "statistical data form" and the case would be put into a "temporarily closed" category. At a later date, the case would be examined again to insure compliance at which time, barring complicating factors, the case will be closed.

Step Eight—If following the joint conference the problem has not been corrected, these cases will be discussed at a weekly meeting of the volunteer and the professional staff. At this point the volunteer relinquishes direct involvement with the case and the professional staff assumes responsibility.

Step Nine—The staff at this point makes direct contact with those federal, state and local agencies which directly impact upon the problem. It is at this juncture that the assistance of the legal aid bureau might be required.

Step Ten—If the problem still persists subsequent to dealings with federal, state and local agencies as well as legal aid, and if the problem is one requiring legal remedy, the case will be turned over to the Attorney General of the State of Maryland. Appropriate follow-up in the form of a written case disposition will be sought from the Attorney General's office upon closure of the case.

Step Eleven—If the persistent problem is not a strictly legal one, but rather requires administrative action which is not forthcoming from the appropriate agencies, then the case will be turned over to the chief executive of the geographic entity involved.

Step Twelve—A monthly meeting will be held by the staff and the volunteers involved to review all cases closed that month. In addition any follow-up or review case will be examined as to proper disposition.

Ancillary Duties of Ombudsman Office

1. Guidelines For Evaluation of Long Term Care Facilities

The Ombudsman Office would within a year subsequent to the start of operations, produce a monograph dealing with methods by which the general public can assess and evaluate the care and services provided within institutions. This will not be a home-by-home evaluation, but rather a general description of what to assess and look for within nursing homes and other long-term care facilities. It is anticipated that this monograph will provide the public with a "measuring stick" for the evaluation of facilities and thus aid in the avoidance of placing patients in facilities which have major deficiencies.

2. Rights of Patients in Long Term Care Facilities

A brief monograph dealing with the civil and individual rights of patients within institutions will be developed by the Ombudsman Office within six months of the start of operations. The monograph will be based on research conducted at the state and national level by a variety of groups dealing with the aged and disabled population. Prior to any publication of such a document, the legal aid bureau will be asked to review it for legal accuracy and comprehensiveness.

3. State and Local Procedures for Evaluation and Certification

The Ombudsman Office will provide for the general public copies of state and local guidelines for the evaluation and certification of patients under the variety of programs of care including Medicaid, Medicare, intermediate, skilled and domiciliary care, public assistance, Old Age Assistance, and so on. These guidelines will be accompanied by a brief description of the manner and process required to gain eligibility for these programs.

4. Appointment of Ombudsman Volunteers as Representative Payees

As the total numbers of aged and chronically ill in long-term care institutions increases, and as the amounts of monies paid to Social Security beneficiaries in these institutions increases, the proper handling of these monies has become a major problem. The Governor's Commission on Nursing Homes has received numerous complaints during the past 18 months dealing with the question of Social Security payments:

1. Not being allowed to see the amount of the check
2. Being denied mandated increases in personal spending money
3. Families being charged for costs over and above personal spending money limits
4. Funds (spending money) co-mingled with funds of facility

Under provisions of the Social Security Administration, it is possible to have a relative or "other person" designated as a representative payee for purposes of handling the money of an institutionalized adult:

"Where it appears that the interest of a Beneficiary would be served thereby, the Social Security Act provides that payment may be made for his use and benefit to a relative or some other person, regardless of the legal competency or incompetency of the beneficiary."

For those persons for whom a representative payee exists, the Social Security Administration has the ability to exercise control and evaluation. There are, however, numerous patients for whom no friend or relative exists and thus the patient either "handles" his own funds or the facility becomes

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the representative payee. It is this latter group which presents the greatest problems and in which the greatest abuses are apparent.

We are suggesting that the voluntary groups named in this proposal could have members named as representative payees for patients in facilities. The volunteers would be in a position to identify those patients in long term care facilities who have been instructed not to list the name of the facility in filing change of address but merely to give the street address of the home. It is this population which the Social Security Administration is "unaware of" and for whom a representative payee has not been considered.

If this program were to be initiated, there might be a small sum paid to the volunteer in return for his services as representative payee. This might be done on a "purchase of service" type agreement.

This proposal was prepared by the Commission staff.

2:

Social Services and the Intermediate Care Facility Caseworker

As part of an attempt to look at the social service needs of patients in nursing homes, and how such services are provided, a study was made of the services provided by intermediate care workers in nursing homes. These workers are employed by the county departments of social services and are responsible for all Medicaid patients in intermediate care facilities. This is the only statewide organized program for the delivery of social services in nursing homes.

Questionnaires were sent to (and returned by) all 37 intermediate care workers in the state. However, not every worker answered every question. At the conclusion of the report there is a copy of the questionnaire and the number of responses for each question.

Half the workers had been working as intermediate care workers for two years or less. Seventeen of the 24 had caseloads of 80 or more, a size that makes adequate delivery of services difficult. Twelve of the 26 workers spent between 50-and-69 percent of their time in the field, while 16 of 34 spent 30-to-49 percent of their time completing forms and related paperwork. The majority had large caseloads, but 24 of 34 felt an ideal size to be less than 80 cases. Several said that the number of cases made it extremely difficult to adequately work with many of their clients.

Thirteen out of 36 workers worked exclusively with intermediate care facility patients. Another 6 had at least 75 percent of their clients in intermediate care facilities (ICF). However, when asked which type of caseload they preferred, 25 out of 35 caseworkers preferred a mixture of ICF clients and others. Half of those who had all ICF clients would prefer the mixture, and nearly all (19 out of 22) of those who had mixed caseloads preferred the mix. The universal reason given for preferring a mixed caseload was that it was difficult to constantly be with the ICF patient, both because the patients are difficult to work with and because it did not allow much time for community contacts. Those who preferred a caseload of all ICF patients felt that the best service could be given when full time could be spent with the elderly patient.

The most common type of training the ICF worker has had is through conferences and seminars. Thirty of the 37 respondents had attended some conferences and seminars. Almost half (20) had participated in the state-sponsored in-service training program.

Although all had had some training, half (17 out of 37) felt that the training was inadequate for the job. Many commented that they found some of the work difficult and wanted more conferences and in-service programs to help them do a better job.

Even though half did not feel their training was adequate, 26 out of 36 felt that they had good support from local departments of social service, a necessary item especially for a worker learning on the job. Not as many workers felt the state provided good support as only 21 out of 35 said this was adequate. Both local and state departments of social services could do more to help give the worker a better understanding of his job. The two most common ways indicated that better support could be given were through more training programs and clearer guidelines. Some respondents indicated that guidelines were sometimes vague and difficult to follow.

Several questions were asked concerning the workers' role, both with the patient and with the nursing home. Our reason for these questions was to clarify some of the activities of an intermediate care worker, which could help in planning programs for incorporating social workers into nursing homes.

Most frequently patients were referred to the caseworker within 30 days of entering the home. Seventeen out of 37 workers indicated this. Nine out of 37 workers said that usually their patients were referred to them after they had been in the home more than 30 days. This becomes significant when noting that 31 workers indicated that the most common problems presented by the patients were adjustment to institutional living (nursing home). The caseworkers' services could certainly be more valuable to both the patient and the home if they could begin working with patients before, or at least immediately upon, entering the home. If adjustment is indeed the most common problem, the most effective time to begin dealing with it is at the time of admission. This could help minimize the problems the patient might have later, including some management problems related to poor adjustment. The only other casework problem frequently encountered was that of family relationships.

After the workers indicated what they thought were the most common casework problems, they were asked to rank in order of frequency the services they actually provided. The services they were to rank were those considered typical of what a social worker might give in a nursing home. Following is a list of these services:

Identifying patient social problems; conferences with nursing home staff; interpreting the social work role to nursing home staff; counseling family of residents; counseling

residents; interpreting medical recommendations to resident and/or family; recognizing medical problems and notifying appropriate personnel; identifying and mobilizing appropriate community services in behalf of client; developing supportive services in nursing home (activity programs, volunteer services, etc.); tying client in with supportive services in nursing homes; discharge planning; personal services for client (letter writing, purchasing from store, transportation, etc.).

For analysis purposes, only the three most frequently given services as noted by each worker were computed.

- tying client in with supportive services in nursing homes;
- discharge planning;
- personal services for client (letter writing, purchasing from store, transportation, etc.).

The most common service was identifying patient social problems (32 out of 97). Second was counseling residents (25 out of 97), a service closely related to the first. From this it can be seen that for most intermediate care workers, the majority of the time is spent in a one-to-one relationship with the patient, helping him adjust to his particular situation, as well as in helping him cope with other difficulties that come up. This in itself can be seen as a valuable service in that it helps enable the patient to participate in and enjoy nursing-home routine.

However, at times a caseworker does more than work exclusively with the patient. He might find that to develop better patient adjustment and participation, contacts with nursing-home staff and the patient's family might be necessary, both to explain why the patient's behavior might be as it is, and to discuss with them how with some alterations of procedures or programs this behavior could change. In relation to this, the third most common service (as shown in the questionnaire) was conferences with nursing-home staff (18 out of 97) and the fourth most common service was counseling family of residents (11 out of 97). None of the other services listed were chosen by more than a small minority of workers as being among the three most common services given.

In light of this, it might be important to develop into any training programs for social workers in nursing homes ways that social work roles can be expanded. Such things as identifying and mobilizing appropriate community services in behalf of the client, developing supportive services in the nursing home, and tying the patient in with these supportive services are vital components of a social service program. Unfortunately, many times the nursing home staff, the patient and/or his family, do not understand what social workers can do and so tend to limit their activities to those contained in a traditional casework concept.

As part of the question of services given, the respondents were asked to name those services most likely to meet resistance from the nursing home

staff. Recognizing medical problems and notifying appropriate personnel (19 out of 71) met the most resistance. Interpreting medical recommendations to residents and/or family was also met with resistance (10 out of 71). This shows the nursing home staff does not see a caseworker involved in anything medical, the role is purely social. This should be questioned, particularly the resistance to interpretations of medical recommendations. The properly trained medical caseworker can perform a valuable service, after talking to the doctor and nursing staff, by helping the patient and his family understand what is meant by certain medical diagnoses or procedures as they relate to fears and anxieties the patient or his family might have.

The second most often mentioned service meeting resistance was developing supportive services in the nursing home (12 out of 71). Again, if the worker stays within the often perceived (but limited) role of casework services, resistance is minimal. If he moves into a more expanded role, particularly when it involves other nursing home staff or in some way questions established procedures, resistance grows. It is unfortunate that developing supportive services for the patient is not actively supported by nursing-home staff.

Even though some services meet more resistance than others, the overwhelming majority of those responding indicated that they, in general, did not get resistance from the nursing-home staff (27 out of 36). Of those who did get resistance, it came most frequently from the administrator.

In terms of understanding what the caseworker does, the respondents indicated that the large majority of the staff did understand their jobs (32 out of 35 for administrators; 28 out of 35 for nurses; and 19 out of 32 for aides). This is undoubtedly true when the narrow definition of caseworker is used, but is questioned that the response would be the same if the job were seen as fully incorporating the twelve items listed earlier. Many administrators had assigned a staff person, untrained to do much of the work related to patient family contacts and possible discharge planning, and felt this was adequate social work.

When asked if their patients understood the work of the intermediate care worker, 28 out of 33 respondents indicated that they did.

Five questions were asked relating to community support services and the patient. First, the intermediate care workers were asked what percent of their patients in nursing homes could live in the community if proper support services were given. Most (23 out of 37) felt that less than five percent could, even with help. This points out that in the opinion of the workers, those patients in intermediate care facilities should be there, or at least in some institutional setting. This runs counter to what many people in the field of aging have said, namely, that 15 to 25 percent of those in nursing homes need not be there.

When asked what percentage of patients referred to them are discharged

to the community, 35 out of 37 workers said less than ten percent. This could indicate that, as was just said, patients in the homes could not live in the community. More important, however, this shows what so many people believe and what patients themselves fear, that few who go into a nursing home ever come out. The nursing home becomes the last stop. If in fact this is true, then it becomes more important that there be social services in homes in order to help the person make adequate adjustment to his institutionalization and to help him maximize his social and emotional potential in the home.

Twenty-two workers out of 35 had difficulty finding needed community support services. However, 10 workers had not had much contact with these services. The workers were then asked to specify which of a list of services they found adequate and which inadequate (inadequate would include the service not being available in a particular area). Responses are given in Table 1.

TABLE 1.

Service	Adequate	Inadequate
Meals on Wheels	9	19
Homemaker service	23	9
Public health	25	6
Instructive Visiting Nurse Service	10	17
Special home services	11	17

It is interesting to note how the intermediate care workers viewed the adequacy of the above services as compared with how hospital social workers viewed the same services. The majority of the hospital social workers found Meals on Wheels adequate; homemaker service inadequate; visiting nurse service adequate; and special home services inadequate. Apparently looking from two different points, namely, the hospital and the nursing home, these community services can appear to be quite different.

There are several conclusions which can be drawn from the questionnaire findings. First, if indeed one of the major problems a patient has is the adjustment to institutional living and to the nursing home, strenuous efforts should be made to have the caseworker make contact with the person before or as soon as he enters the home. In this way some possible behavior problems could be minimized, but more important, this will help the individual take maximum advantage of what the home provides.

Second, as part of the training administrators are required to participate in, there should be a course dealing with social work in nursing homes. This should include the types of services social workers are trained to provide,

services that are not only clinical in nature, but also supportive, recreational, and community oriented. It should also include discussions on common casework problems patients have, and how these can be handled.

Finally, different methods of developing social service programs in nursing homes should be explored. At present the only organized program for this is the intermediate care workers who can only reach a small percent of nursing home patients. In the present state licensing requirements for skilled nursing homes there is a requirement that medically related social needs of the patient be identified; that a nursing home staff person shall be responsible for necessary action relating to the social needs; that a qualified social worker be available for aid in seeking solutions to the patients needs; and that signed social summaries shall be maintained for each patient. Up to very recently these requirements have not been enforced.

QUESTIONNAIRE FOR INTERMEDIATE CASE WORKERS

1. How long have you been working in nursing homes?
A. less than one year 4 D. three years 7
B. one year 4 E. more than three years 11
C. two years 11
2. What is present size of your caseload?
A. 60-69 cases 2 C. 80-99 cases 4 E. 150-200 cases 8
B. 70-79 cases 6 D. 100-149 cases 9 F. over 200 cases _____
3. What percent of your caseload is made up of ICF clients?
A. less than 50% 9 C. 75-99% 6
B. 50-74% 8 D. 100% 13
4. What do you feel is the ideal caseload size for delivery of adequate services?
A. 40-59 cases 9 C. 80-99 cases 10
B. 60-79 cases 15 D. 100 or more cases 1
5. What type of caseload would you prefer?
A. all ICF residents 10 B. mixture of ICF and others 25
C. what are reasons for preference _____

6. About what percent of your time is spent in the field?
A. less than 10% 1 C. 30-49% 6 E. 70-100% 3
B. 10-29% 4 D. 50-69% 12
7. What percent of your time is spent completing required forms and related paperwork?
A. less than 10% 0 C. 30-49% 16 E. 70-100% _____
B. 10-29% 5 D. 50-69% 13

Social Services in Nursing Homes

8. What type of training have you had for work as an Intermediate Care worker?
- A. special inservice training 20 D. books and/or journals 22
B. conferences and/or seminars 30 E. other 3
C. courses 10 F. none _____
9. Do you feel your training has been adequate?
- A. Yes 18 B. No 17
10. Do you feel there has been adequate support from Social Service Departments?
- Local Level: State Level:
A. Yes 26 B. No 10 A. Yes 21 B. No 14
11. If not, how could the support be strengthened?
- A. training programs 13 C. meetings 10 E. other 6
B. guidelines 13 D. informal discussions 10
12. On the average, when is client referred to you?
- A. before entering nursing home 5
B. immediately upon entering nursing home 6
C. within 30 days of entering home 17
D. more than 30 days after entering nursing home 9
13. What is most common casework problem presented by clients in nursing homes?
- A. adjustment to the nursing home 12
B. adjustment to institutional living 19
C. adjustment to other patients 3
D. financial problems 8
E. family relationships 11
F. difficulties understanding or accepting medical diagnoses _____
G. other _____
14. Below is a list of services you might provide for your clients. Rank them from 1 to 12, beginning with the service you provide most frequently.
- A. 32 identifying patient social problems
B. 18 conferences with nursing home staff
C. 6 interpreting the social work role to nursing-home staff
D. 11 counseling family of residents
E. 25 counseling residents
F. 1 interpreting medical recommendations to resident and/or family
G. 3 recognizing medical problems and notifying appropriate personnel
H. 3 identifying and mobilizing appropriate community services in behalf of client
I. 3 developing supportive services in nursing home (activity programs, volunteer services, etc.)
J. 1 tying client in with supportive services in nursing homes
K. 3 discharge planning
L. 1 personal services for client (letter writing, purchasing from store, transportation, etc.)

Institutions and Long-Term Care

15. Do you get resistance from members of nursing staffs to some services you provide your clients?

A. Yes 9

B. No 27

16. If yes, which staff (check all that are appropriate)

A. Administrator 8 B. Nurses 5

C. Aides 2

17. Do you feel nursing home staffs understand your work as an Intermediate Care worker?

Understand

A. administrator 32

B. nurses 28

C. aides 19

Don't understand

A. administrator 3

B. nurses 7

C. aides 13

18. Do you feel that your clients understand your work as an Intermediate Care worker?

A. Yes 28

B. No 5

19. Which services are most likely to meet resistance from the staff?

A. 7 identifying patient social problems

B. 5 conferences with nursing home staff

C. 4 interpreting the social work role to nursing-home staff

D. 0 counseling family of residents

E. 2 counseling residents

F. 10 interpreting medical recommendations to resident and/or family

G. 19 recognizing medical problems and notifying appropriate personnel

H. 3 identifying and mobilizing appropriate community services in behalf of client

I. 12 developing supportive services in nursing home (activity programs, volunteer services, etc.)

J. 2 tying client in with supportive services in nursing homes

K. 6 discharge planning

L. 1 personal services for client (letter writing, purchasing from store, transportation, etc.)

20. What percent of clients that you see, in your judgment, could actually live in the community if proper support services were given? (service such as Meals-on-Wheels, IVNA, homemaker service, etc.)

A. less than 5% 23 C. 11-20% 3

E. more than 30% 2

B. 6 to 10% 4 D. 21-30% 5

21. Approximately what percent of the clients referred to you are eventually discharged from nursing homes to community (not to acute hospitals)?

A. less than 10% 35 C. 21-30%

E. more than 40%

B. 11 to 20% 2 D. 31-40%

Social Services in Nursing Homes

22. In general, have you had difficulty finding adequate community-support services for a resident who might be able to return to community if services were available?

A. Yes 22

B. No 3

C. not much contact with community services 10

23. Check one column for each of the following:

Adequate

Inadequate

A. 9

G. 19

Meals-on-Wheels

B. 23

H. 9

Homemaker Service

C. 25

I. 6

Public Health

D. 10

J. 17

Instructional Visiting Nurse Association (IVNA)

E. 11

K. 17

Special Home Services

F. 5

L. 11

Other (specify) _____

24. Are there any community services or programs *not* now available that you feel are needed?

Yes 30

No 1

Explain what these would be _____

We would appreciate any additional comments you may have.

This report was prepared by the Commission staff.

3:

Nursing Home Visits: An Evaluation

To avoid confusion about the nature of the facility being discussed, here is a list of the various types of institutions and the level of care they provide:

General Hospital (e.g., Johns Hopkins, University of Maryland)

These facilities provide medical and nursing care to the acutely ill with the aim of restoring the individual to health within a relatively brief time.

Chronic Disease Hospital (e.g., Montebello, City Hospitals)

These facilities provide medical care to persons incapacitated by illness, with the intent and, indeed, mandate to rehabilitate and return them to the community.

Skilled Nursing Home (e.g., Bolton Hill, House-In-The-Pines, Stella Maris Hospice)

These institutions maintain the facilities and staff necessary to render skilled nursing care (which means care by a registered nurse, or by a licensed practical nurse under her supervision).

Intermediate Care Facilities—Type A (e.g., Ashburton, Harbor View, Jenkins Memorial)

These institutions provide Long Term Care to residents whose illness is not acute and whose proper care requires no more than eight hours a day under the supervision of an RN or LPN.

Intermediate Care Facilities—Type B (e.g., Levindale, Frederick Nursing and Convalescent Center)

These institutions provide services which a person normally performs himself, but for which he is now dependent upon others because of advanced age, physical, or mental limitations.

The staff of the Governor's Commission on Nursing Homes selected at random and visited 16 facilities representing a cross section of the institutional types.

In addition, we based our decision upon ownership, selecting facilities from: 1) The proprietary sector (corporation and single owner); 2) public facilities (city and county); 3) non-profit (organizationally based and foundation financed); and 4) sectarian facilities (representing major denominational groups).

The visits were made to familiarize the Commission staff with nursing-care facilities, to identify major problems, and to provide owners and administrators of the facilities an opportunity to present their views to the Commission.

During visits to proprietary homes it became clear that their owners and administrators are convinced that "for-profit homes" are the best way to provide quality nursing care. They believe proprietary care is by far the most efficient because the profit motive ensures that the patient receives maximum care for the dollar.

It is important that we understand the differences between the proprietary home which accepts only private paying patients and those profit homes which accept Medicaid and other publicly assisted patients. Those accepting only private patients appear to have far fewer problems, primarily because they receive sufficient funds both to provide decent care and maintain their level of profit. The facilities which accept public patients, however, bitterly resent what they believe is a meager state subsidy to the institution (\$18 a day for skilled and \$17 a day for intermediate A care).

If one questions the non-profit home about the financial aspects of care, the answers are generally similar to those of proprietary institutions. The non-profit homes also feel that the current State subsidy is far too little to ensure adequate nursing care. The proprietary homes quickly devised a method that allowed them to continue to accept Medicaid patients without endangering their ten percent profit margin: They simply refused to take the very "ill" patients requiring sophisticated and expensive medical and nursing care. (It must be made clear that this description is not pejorative, because it seems clear that the level of reimbursement is, in reality, not sufficient).

For the non-profit home, however, the situation did not allow this skillful manipulation. Many of these homes, by virtue of their charter or their funding, must accept most patients and thus the patient mix was not nearly as economically advantageous. These homes claim that their high proportion of very ill patients forces them to spend far more than the amount provided by the state, making it necessary for them to spend endowment or simply go further and further into the red.

Thus, the answers to the first seven questions on the "checklist" varied

dramatically depending upon the nature of the ownership or the type of patient (private, Medicaid; very ill, moderately well).

Perhaps the most glaring deficiency present in the homes visited was the virtual absence of formal, comprehensive social service programs. Far too many of the homes appeared to be operating under the assumption that activities such as bingo, songfests and the like, add up to comprehensive social services. In discussions, the owners and administrators offered these reasons for the absence of such programs: 1) too expensive; 2) lack of trained personnel; and 3) they saw no need for such a program.

While some of the proprietary homes had a social worker consultant on the staff, it appeared that little use was made of their skills, and in many instances they were perceived as a threat by the administrator and his staff.

Another major problem encountered during these visits is the difficulty the nursing homes have hiring, keeping, and utilizing para-professionals. The owners and administrators claim that the problem centers around union difficulties, while the para-professionals argue that low pay and low morale result in a high turnover. We suspect that the truth lies between these two extremes. It is true that many of the homes have had no experience in dealing with union personnel, resulting in antagonism, alienation, and continuous friction between the employees and the administrator, as well as the professionals. It seems clear that what is required is an in-service training program for the para-professionals, and a coming together of the state, the nursing homes and the union, in an effort to solve some of the more pressing manpower problems.

This report was prepared by the Commission staff.

4:

Nursing Home Placements

Transferring patients from acute hospitals to long-term-care institutions, usually nursing homes, is a long and difficult process, and one that many times does not in the end serve the patient's best interests. The following report demonstrates many of the failings in terms of inclusiveness, adequacy, equity, and administration that are inherent in the institutional transfer system.

This report is the analysis and summary of a questionnaire sent to social-work departments in all acute hospitals in Maryland. They were asked to respond to questions concerning five patients, picked at random, in their hospital requiring nursing-home placement.

In terms of inclusiveness, the number of patients for whom a home was never found illustrates the lack of this placement service for all who were eligible to receive it.

Despite calls to up to 60 homes in some cases, beds in nursing homes were not found for one-fifth of the sample cases. For these patients, alternatives had to be found, ranging from placement in an institution other than a nursing home, to being sent home, without support services. No amount of effort was able to obtain the needed nursing-home placement for these patients.

There is also a lack of community support services for all those who could benefit by these services, indicating something short of inclusive coverage. The high number of respondents who felt such programs as Meals-on-Wheels and Homemaker Services needed to be developed or expanded and the listed services and programs not now available, but needed in the communities, indicates the degree to which patients are unable to receive the quantity and variety of services they require.

The question of adequacy of services is raised when one notes that almost a third (29%) of the placements were not considered the best one for the patient. The three reasons most commonly given for this were: 1) the home's location made it difficult for the family to visit; 2) the patient needed more

care than the home could provide; and 3) the patient was sent home when he should have been in a nursing home. The fact that 64% of the patients were in the hospital longer than necessary could also indicate that the proper service was not being utilized. The patients no longer needed acute care services, and so should have been in a facility that could have given the type care they needed, thus releasing the hospital bed for someone who needed acute care. The number of extra days these patients were in the hospital (up to 7 days for 32% of the patients and 8 to 14 days for 33% of the patients) shows the extent to which acute services were being misused.

The question of equity brings out one key problem of proper discharge planning for the elderly. Social workers indicated that nursing homes were selective, choosing those patients requiring the minimum amount of care. Thus those patients needing more care have less of a chance of finding an appropriate placement. And if they are lucky enough to find a home, they have less of a chance of getting the kind of care they require.

One social worker noted that private patients have a better chance of receiving appropriate placement quickly because of their ability to adequately pay for the services they need. The private patient usually has first choice when nursing-home beds are available.

Equity is strained in the delivery of community support services. Those on Medicaid and especially those in the "gray areas," too rich for Medicaid, but too poor to pay for extra services, are caught not being able to afford community services necessary if they are to remain in the community as long as possible. For example, one social worker pointed out that Medicaid only covered a Homemaker for four hours a day five days a week, inadequate for the needs of her patient.

The questionnaire responses pointed up several areas of administrative ineffectiveness. First, there were delays in beginning discharge planning for one-half of the patients. Eliminating these delays could cut down the average number of extra days the patients stay in the hospital.

Only 20% of the patients referred for discharge planning entered nursing homes as private patients. Of the remaining 80% who entered homes on medical assistance, one-half applied for this while in the hospital. The problem of getting Medicaid approval quickly (in one-fourth of the cases where Medicaid was applied for, the process took longer than 2 weeks) points up the need to devise ways for this administrative procedure to be shortened.

The process of finding a home is inefficient. Having every social worker and/or family member needing to find a nursing home call home after home until one is found, illustrates the duplication of effort. Several social workers suggested a central registry as a way of combating this problem.

The average time social workers spend making arrangements for placement was ten hours per patient, time that could have been spent in

direct patient and patient-family services, a rather poor use of their time and training.

The questionnaire points up the need to look more closely at several areas in the system that transfers patients into long-term-care facilities, especially nursing homes. Changes are needed to improve this system.

Following is detailed analysis of the questionnaire.

Code used on following pages:

Western Maryland: Allegany, Frederick, Garrett and Washington Counties

Baltimore City: Baltimore City only

Baltimore Metropolitan: Anne Arundel, Baltimore, Carroll, Harford and Howard Counties

National Capital: Montgomery and Prince George's Counties

Southern: Calvert, Charles, and St. Mary's Counties

Eastern Shore: Cecil, Dorchester, Caroline, Kent, Queen Anne's, Somerset, Talbot, Wicomico and Worcester Counties

TABLE 1. QUESTION 1: How long after patient entered hospital was he referred to social services in connection with nursing-home placement?

Answers	Western Maryland	Baltimore City	Baltimore Metropolitan	National Capital	Southern	Shore	Eastern Total
Immediately	3	5	18	3	0	5	34
7 days or less	9	14	21	8	3	5	60
8-14 days	8	10	20	6	1	5	50
15-30 days	3	13	20	9	0	3	48
31-60 days	1	2	3	1	0	2	9
60+ days	1	0	1	1	1	0	4
Referred from outpatient or emergency room	0	5	5	1	0	0	11

As Table 1 shows that, over one-half of the patients represented in the questionnaires were referred to social services after having been in the hospital at least a week. Only Southern Maryland and the Eastern Shore varied from this. Apparently social services in many cases is not being involved from the time of the patients' admissions. Thus it is not able to have maximum time for appropriate discharge planning and for adequate support services for the patient and his family while he is in the hospital. The social worker should be seen more as an integral part of the hospital team that serves the patient from the time he enters the hospital, rather than simply one who finds placement when the staff feels it is necessary.

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TABLE 2. QUESTION 2: If delay in referral to social services, what were some of reasons?

Answers	Western Mary- land	Balti- more City	Baltimore Metro- politan	National Capital	Southern	Eastern Shore	Total
No delay	13	21	39	10	3	10	96
Change in patient's condition	8	9	13	4	0	3	37
Patient or family re- sisted	2	3	6	2	0	0	13
Other	0	5	9	3	0	1	18
Failure to recognize need	1	9	12	10	2	4	38

For half of the patients referred to social services, there was some delay in the referral (Table 2). In other words, if the referral had been made without a delay, possibly more time would have been available for appropriate planning and/or the patient could have left the hospital sooner (see Tables 10 and 11). The problem of referral delay is severest in the National Capital area, followed by Baltimore City. The two most common reasons for the delay were change in condition of the patient and the staff's failure to recognize the need for discharge planning, the latter reason, with proper education, being correctable.

TABLE 3. QUESTION 3: Did this patient need Medicaid certification before entering nursing home?

Answers	Western Mary- land	Balti- more City	Baltimore Metro- politan	National Capital	Southern	Eastern Shore	Total
No, had it	6	26	37	7	1	9	86
Yes	12	18	34	21	1	6	92
No, private patient	7	4	16	2	2	4	35

Only 20% of the patients referred for discharge planning entered the nursing homes as private patients (Table 3). As many social workers indicated, finding a placement for a medical patient is more difficult than for a private patient because of the state's limited nursing-home reimbursement, and the time it takes to process the SHD 29 form and get medical certification. The differences were the greatest in the National Capital area and Baltimore City, where only 7% and 9% of those referred were placed as private patients.

Of the patients needing Medicaid before entering a nursing home, about one-half applied for it while in the hospital, although, as Table 3 shows, there was considerable variance among the areas of the state.

TABLE 4. QUESTION 4: If patient needed Medicaid certification, how long did the process take?

Answers	Western Mary- land	Balti- more City	Baltimore Metro- politan	National Capital	Southern	Eastern Shore	Total
1-3 days	0	2	8	0	1	0	11
4-7 days	6	10	17	3	0	0	36
8-14 days	2	2	4	9	0	2	19
15-21 days	0	2	3	4	0	0	9
22-30 days	2	1	1	3	0	1	8
30+ days	0	1	1	1	0	1	4

For 87 patients in the survey, Medicaid certification was sought (Table 4). Fifty-four percent of the certifications were completed in seven days or less, with 13% being completed within 3 days. However, for 24% the process took longer than two weeks. The delay in certification is greatest in the National Capital area where 85% of the Medicaid certifications took more than one week. The process took the least amount of time in the Baltimore Metropolitan area, where 75% of the certifications were processed in one week or less. Since in Maryland the average length of stay in an acute hospital is eight days, undoubtedly delays in the Medicaid certification process contribute to patients having to stay in the hospital longer than necessary, which is detrimental to both the patient and the hospital.

TABLE 5. QUESTION 5: Who located nursing home?

Answers	Western Mary- land	Balti- more City	Baltimore Metro- politan	National Capital	Southern	Eastern Shore	Total
Social services department	19	40	58	21	2	11	151
Hospital staff	2	4	17	0	2	5	30
Family, friends	1	0	6	4	0	1	12
Not located	5	8	17	7	1	3	41

Of the patients for whom nursing homes were found, 65% were found by the social service department (Table 5). No home was located for 18% of the patients, even though placements had been determined as appropriate for the patient. Thus, the difficulty of finding appropriate beds, especially for those

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who are intermediate A or B, in need of a high level of nursing care, and/or poor, means that providing the services most needed by the patient has to be compromised.

TABLE 6. QUESTION 6: How many nursing homes were contacted on behalf of the patient?

Answers	Western Mary- land	Balti- more City	Baltimore Metro- politan	National Capital	Southern	Eastern Shore	Total
1-5	11	23	43	12	4	17	110
6-10	6	8	16	6	0	3	39
11-20	3	11	18	6	0	1	39
21-30	0	5	7	2	0	0	14
30+	1	2	3	3	0	0	9

Because in Maryland there is no registry of available nursing-home beds, each person looking for a bed has to call homes individually. This can lead to duplication and unnecessary loss of time. In this survey, one-half (52%) of the social workers were able to either locate a home or determine that nothing was available after calling one to five homes (Table 6). However, 26% of the workers had to call eleven or more homes before being able to develop some plan for the patient. The problem was most acute in the National Capital area, where 59% of the social workers had to contact six or more homes before placement could be made. Obviously, in the state there are great variances as to the number of homes available to choose from in a particular area, but as many social workers indicated, the problem of finding beds is statewide.

TABLE 7. QUESTION 7: If no home was located, what happened to patient?

Answers	Western Mary- land	Balti- more City	Baltimore Metro- politan	National Capital	Southern	Eastern Shore	Total
In hospital	3	4	8	4	0	2	20
Went home with- out services	2	4	5	3	1	3	18
Went to facil- ity other than nursing home	2	2	3	1	0	6	14
Went home with services	1	1	3	2	1	1	9

Of the total patients represented in the survey (see Table 7), sixty-one were not able to be placed in nursing homes, although this was medically indicated. Of these, one-third were still in the hospital waiting placement or

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an alternative, and two thirds had other alternatives worked out for them. However, in some cases the alternatives were only temporary and nursing-home placement was eventually made. In the cases where a temporary alternative was made, the patient had to go through an extra adjustment, and social workers commented on how difficult this was for the patient. It is interesting to note that eighteen patients who were to go to nursing homes went home without community support services, obviously an inadequate alternative.

TABLE 8. QUESTION 8: Do you feel the placement made was the best one for the patient?

Answers	Western Mary- land	Balti- more City	Baltimore Metro- politan	National Capital	Southern	Eastern Shore	Total
Yes	16	30	56	22	4	10	138
No	7	14	21	7	0	8	57
None made yet	1	3	6	3	0	2	15

Because of the difficulty in finding adequate placement for the patient, sometimes less than ideal situations are chosen as alternatives. The survey indicated that in 29% of the cases the placement was not the best one for the patient (See Table 8). Questionnaires from Southern Maryland showed that all of the placements were satisfactory, in contrast to the Eastern Shore where finding adequate placement was the most difficult. Forty-four percent of their placements were not the best ones for the patients. This shows that one of the breakdowns in the delivery of services to the chronically ill and aged can be between acute hospitalization and placement in long-term-care

TABLE 9. QUESTION 9: What are some of the reasons if the placement was not the best one for patient?

Answers	Western Mary- land	Balti- more City	Baltimore Metro- politan	National Capital	Southern	Eastern Shore	Total
Nursing home could not pro- vide enough care	3	6	9	1	0	0	19
Location of nursing home	5	3	8	2	0	5	23
Patient sent home but should have been in nursing home	2	4	8	3	1	2	20
Other	0	2	2	3	0	2	9

facilities. Not being able to provide the type of post-hospital care that most benefits the patient can, to some degree, negate the efforts made by the hospital for that particular patient. If a patient is to be provided adequate care, care that requires input from several different sources, each one needs to be accessible when needed to make the other services being provided valuable to the patient.

The most common reason why the placement was not the best for the patient was that the home's location made it difficult for the family to visit (Table 9). However, the other two reasons, namely, the patient needed more care than the home could provide, and the patient was sent home when he should have been in a nursing home, were given almost as frequently. The most common "other" was that the patient had to go to one facility while waiting for the one he needed. Thus, if the bed he needed finally became available, it meant another move, something the social workers said was very difficult for the patient. If the appropriate bed did not become available, the patient had to stay in the inappropriate facility.

TABLE 10. QUESTION 10: Was patient in hospital longer than necessary due to difficulty in finding a nursing-home placement and/or getting Medicaid certification?

Answers	Western Mary- land	Balti- more City	Baltimore Metro- politan	National Capital	Southern	Eastern Shore	Total
Yes	21	28	53	24	3	9	138
No	3	20	34	6	2	11	76

As has been indicated earlier, difficulties in finding appropriate placement for the patient and the difficulty in getting Medicaid certification can lead to the patient having to stay in the hospital longer than necessary, obviously detrimental to both patient and hospital, in addition to being detrimental to whoever is paying for the hospital stay. According to the survey (See Table 10), 64% of the patients were in the hospital longer than necessary, a figure that shows a need for better hospital utilization, but more important, shows the difficulty in effecting the continuation of needed services. When patients stay in the hospital longer than necessary, it not only becomes counter-productive to them, but it is detrimental to those needing to enter the hospital. In the specific regions of the state, the problem seems to be most acute in Western Maryland, where 88% of the patients were in the hospital longer than necessary. The National Capital area indicated that 80% of its patients were in the hospital too long. The survey showed that on the Eastern Shore, 45% of the patients were in the hospital longer than necessary, the best percentage in the state. However, as a previous question

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indicated, they had the highest percentage of placements made that were not the best one for the patient.

TABLE 11. QUESTION 11: If the patient was in the hospital longer than necessary, how many extra days was he there?

Answers	Western Mary- land	Balti- more City	Baltimore Metro- politan	National Capital	Southern	Eastern Shore	Total
1-3 days	1	2	5	1	0	2	11
4-7 days	2	8	17	5	0	2	34
8-14 days	7	10	18	9	0	2	46
15-20 days	7	1	7	8	0	1	24
21-30 days	3	3	3	1	1	1	12
30+ days	3	4	5	1	1	0	14

As the figures in Table 11 indicate, not only do a large percentage of patients stay in the hospital longer than necessary (64%) but 32% of these are in the hospital up to a week longer than necessary, and 33% of the patients are in the hospital 8 to 14 days longer than necessary. As indicated earlier, this is the time that the patient is just waiting, time that a bed is being used when it is more needed by someone else, and time that is being paid for unnecessarily.

TABLE 12. QUESTION 12: Were pressures put on you by hospital staff to move patient as quickly as possible?

Answers	Western Mary- land	Balti- more City	Baltimore Metro- politan	National Capital	Southern	Eastern Shore	Total
Yes	12	31	55	16	1	10	126
No	9	16	32	14	4	10	85

The survey indicated that for 60% of the patients, pressure was put on the social work staff to move them as quickly as possible (See Table 12). Hospitals, trying to utilize their beds as appropriately as possible, tend to apply pressure when a patient occupies a bed unnecessarily. In some cases this is because some staff members are not fully aware of the difficulties in making appropriate placement. The pressure was most prevalent in Baltimore City and least prevalent in Southern Maryland and on the Eastern Shore.

Even though pressure was put on the social work staff in over one-half of the cases in the sample, this pressure affected placement only one-fourth of the time (See Table 13). Unfortunately, one-fourth is too high when

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TABLE 13. QUESTION 13: If there were pressures, did these affect appropriateness of nursing home placement?

Answers	Western Maryland	Baltimore City	Baltimore Metropolitan	National Capital	Southern	Eastern Shore	Total
Yes	3	10	15	4	0	4	33
No	10	22	37	17	3	7	96

considering that thirty-three sample patients had to accept less than satisfactory arrangements because adequate arrangements could not be found in the time span of their acute illness. The pressure had the greatest effect in the Eastern Shore area, where it affected the placement of 36% of the patients. Baltimore City was next with 31%. Southern Maryland and the National Capital area showed the least effects of the pressure.

TABLE 14. QUESTION 14: Approximately how much time did you spend making arrangements for placement?

Answers	Western Maryland	Baltimore City	Baltimore Metropolitan	National Capital	Southern	Eastern Shore	Total
1-5 hours	13	12	34	11	4	15	89
6-10 hours	10	17	27	5	0	1	60
11-15 hours	1	12	14	5	0	3	35
16-20 hours	1	5	7	6	0	1	20
20+ hours	0	2	6	8	0	0	16

Forty-four percent of the workers were able to make some placement arrangements in five hours of work or less (See Table 14). (This time is not necessarily concurrent, it is accumulated time). Sixty-eight percent were able to make arrangements within ten hours of work. The question is raised as to whether or not time taken for this by the staff is time taken from other tasks they are trained for, and tasks potentially more beneficial to the patient and his family.

TABLE 15. QUESTION 15: In general, have you had difficulty finding adequate community-support services for a patient who wants to, and could, remain in the community with these services?

Answers	Western Maryland	Baltimore City	Baltimore Metropolitan	National Capital	Southern	Eastern Shore	Total
Yes	21	30	42	14	4	5	116
No	0	3	3	4	0	10	20
No contact	0	9	31	9	1	4	54

The last three questions deal with the workers' knowledge of community-support services, and his feelings about the adequacy of these services.

In question 15 (Table 15), 10% of those completing the questionnaire felt they did not have much contact with community services. Of the rest, 68%, felt they had difficulty finding community-support services. Western Maryland showed the greatest problem with all the workers indicating they had some difficulty. Baltimore City was next, with 77% of the workers expressing difficulty. The problem is least acute (in relative terms) in the Eastern Shore area where 55% of the workers expressed difficulty in finding community-support services.

The fact that throughout the state over one-half of those completing the questionnaire had difficulty in getting adequate support services, coupled with the data indicating the difficulty in finding adequate long-term-care facilities as quickly as needed, shows the frustrations produced in trying to make discharge plans with, and for, the patient. Unfortunately, it is the patient who many times loses because of the difficulty in being able to make adequate plans because of lack of facilities and services.

Several of those completing the questionnaire indicated that as they found delays in finding long-term placement, they turned to the community for

TABLE 16. QUESTION 16: Are the following adequate or inadequate: Meals-on-Wheels, homemaker service, Department of Social Services (DSS), Instructive Visiting Nurse Association (IVNA), special home services, and other.

Answers	Western Mary- land	Balti- more City	Baltimore Metro- politan	National Capital	Southern	Eastern Shore	Total
<i>Adequate</i>							
Meals on Wheels	10	21	32	14	0	5	82
Homemaker service	15	6	21	4	0	5	51
DSS	22	11	37	5	0	20	105
IVNA	10	24	39	7	0	10	100
Special home services	3	11	11	5	0	0	30
Other	0	0	0	4	0	0	4
<i>Inadequate</i>							
Meals on Wheels	10	5	20	9	4	15	53
Homemaker service	5	25	37	21	4	15	107
DSS	0	11	11	15	0	0	37
IVNA	10	3	12	5	0	10	40
Special home services	15	10	15	10	4	15	69
Other	2	2	12	6	0	5	27

temporary support while the patient waited. However, this was difficult for some to find, leaving the patient at home waiting for a bed with no services.

In question 16 (Table 16) those filling out the questionnaire were asked to evaluate five community services in terms of adequacy or inadequacy (which includes non-existence in the community).

I. Meals on Wheels

In the state 60% felt the service was adequate. Many indicated the service was certainly needed, and that for those served, it served well, but it was non-existent in many areas and in other areas there was a long waiting list.

II. Homemaker Service

Sixty-one percent of those who responded indicated that the service was inadequate. Some reasons given were: it was difficult to make contact with those providing the service; waiting lists were long; and the service was too restrictive for the needs of some patients (too few hours allowed, for example). The inadequacy was particularly apparent in Baltimore City (81%) and the National Capital area (80%). In contrast, 75% of those completing questionnaires from Western Maryland felt the service was adequate.

III. Department of Social Services

Of the five programs rated, the Department of Social Services had the highest adequacy rating (74%) statewide. Everyone responding in Western Maryland and on the Eastern Shore felt it was adequate in their areas. However, in Baltimore City only 50% felt it was adequate, and in the National Capital area only one-third felt it was adequate, showing the wide variance among the subdivisions of the state. However, since what was actually meant by Department of Social Services was not clearly defined, the variance could partly be explained by the lack of clarity of the question.

IV. Instructive Visiting Nurse Association

Seventy-one of the questionnaires statewide indicated this service was adequate. In contrast to most of the other services, the questionnaires from Baltimore City were highly favorable (88%) and in fact, several made comments about its importance to them in discharge-planning efforts. This program seems to be least successful in Western Maryland and the Eastern Shore area, where only one-half indicated it was adequate.

V. Special Home Services

Statewide, 30% of those responding felt this service was adequate; the rest found it inadequate or nonexistent.

Nursing Home Placements

Most of those completing the questionnaires indicated services they would like to see developed (question 17).

The most commonly listed need was for more nursing-home beds, especially intermediate A and B beds. In addition, there was a strong indication that more beds were needed for patients too sick for nursing homes to take as skilled patients, but who did not get classified as needing chronic care.

Many indicated that more patients could go home if more complete homemaker services were available, namely, more hours per day, more hours per week, and for an indefinite period.

Other community services listed as needing development or expansion include: Meals-on-Wheels, transportation, foster care, IVNA, mobile clinics, day-care centers and home-sitting services for elderly.

One other area of concern is the prepayment problem. Patients in the "gray" area, that is, patients who are not eligible for Medicaid but are living on fixed incomes, have difficulty getting what services are available in the community because of their limited resources. Workers indicated that they could not get services they needed because of no way to pay for them.

NURSING HOME PLACEMENT QUESTIONNAIRE

1. How long after patient entered hospital was he referred to social services in connection with nursing-home placement?

<input type="checkbox"/> immediately	<input type="checkbox"/> 15 to 30 days	<input type="checkbox"/> referred from
<input type="checkbox"/> 7 days or less	<input type="checkbox"/> 31 to 60 days	<input type="checkbox"/> outpatient or
<input type="checkbox"/> 8 to 14 days	<input type="checkbox"/> more than 60 days	<input type="checkbox"/> emergency room

2. If delay in referral to social services, what were some of the reasons?

<input type="checkbox"/> no delay	<input type="checkbox"/> doctor or other medical staff failed to recognize need for discharge planning
<input type="checkbox"/> change in patient's condition made nursing-home placement appropriate	
<input type="checkbox"/> patient or family resisted referral to nursing home	
<input type="checkbox"/> other (explain) _____	

3. Did this patient need Medicaid certification before entering the nursing home?

<input type="checkbox"/> no, already had	<input type="checkbox"/> no, entered as private patient
<input type="checkbox"/> yes, needed it	

4. If patient needed Medicaid certification, how long did the process take?

<input type="checkbox"/> 1 to 3 days	<input type="checkbox"/> 8 to 14 days	<input type="checkbox"/> 22 to 30 days
<input type="checkbox"/> 4 to 7 days	<input type="checkbox"/> 15 to 21 days	<input type="checkbox"/> specify if longer

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5. Who located nursing home?
_____ social services dept. _____ patient's family or friends
_____ other hospital staff _____ home was not located
6. How many nursing homes were contacted on behalf of the patient?
_____ 1 to 5 _____ 11 to 20 _____ more than 30
_____ 6 to 10 _____ 21 to 30 (specify) _____
7. If no home was located, what happened to patient?
_____ still in hospital _____ went home with community-support services
_____ went home without community-support services
_____ sent to facility other than nursing home (specify) _____
8. Do you feel the placement made was the best one for the patient?
_____ yes _____ no placement has yet been made
_____ no
9. What are some of reasons if placement was not best one for patient?
_____ patient needed more care than home could provide
_____ home's location made it difficult for family to visit
_____ patient was sent home when he should have been in a nursing home
_____ other (specify) _____
10. Was patient in hospital longer than necessary due to difficulty in finding a nursing home placement and/or getting Medicaid certification?
_____ yes _____ no
11. If patient was in hospital longer than necessary, how many extra days was he there?
_____ 1 to 3 days _____ 4 to 7 days _____ 8 to 14 days
_____ 15 to 21 days _____ 21 to 30 days _____ more than 30 days (specify) _____
12. Were pressures put on you by hospital staff to move patient as quickly as possible?
_____ yes _____ no
13. If there were pressures, did these affect appropriateness of nursing-home placement?
_____ yes _____ no
14. Approximately how much time did you spend making arrangements for placement?
_____ 1 to 5 hours _____ 11 to 15 hours _____ more than 20 hours (specify) _____

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15. In general, have you had difficulty finding adequate community-support services for a patient who wants to, and could, remain in the community with these services?

_____ have difficulty _____ do not have difficulty
_____ have not had much contact with community services

16. Check one column for each of following:

<i>Adequate</i>	<i>Inadequate</i>	
_____	_____	Meals on Wheels
_____	_____	Homemaker Service
_____	_____	Dept. of Social Services (DSS)
_____	_____	Instructional Visiting Nurse Association (IVNA)
_____	_____	Special Home Services
_____	_____	Other (specify) _____

17. Are there any community services or programs *not* now available that you feel are needed?

_____ yes _____ no

Explain what these would be _____

Note: We would appreciate any additional comments you have concerning this problem of finding adequate and appropriate long-term care for the elderly. Please use reverse side if more space is needed. Thank you for your cooperation.

This report was prepared by the Commission staff.

5:

The Aged in Maryland State Mental Hospitals

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I. INTRODUCTION

The purpose of this report is to assess the situation in Maryland of persons 65 years or older in state mental hospitals. The report, which is a study of a random sample of recently admitted geriatric patients, attempts to characterize this group and to highlight their social, psychiatric, and medical problems. There is also a larger perspective: For example, this report also concerns itself with how the older patient could again achieve a measure of independent living in the community and how preventive intervention might help avoid hospitalization altogether.

This report does not presume to be a definitive statement of a complicated situation. Rather, it highlights special features, problems, and alternatives in providing services for older citizens, especially those who may need the resources of the Maryland Department of Health and Mental Hygiene.

This report reflects the concern of the Governor's Commission on Nursing Homes and the Department of Health and Mental Hygiene for the large number of older persons who need both community and hospital-based services. Without the support and cooperation of the Department of Mental Hygiene this study would not have been possible.¹

The philosophical position of this study is that shared by all the helping professions: Every person has the right to the fullest use and realization of his or her capacities. The older person in particular has the right to live out his days without undue suffering from poverty, physical illness, mental illness, and social isolation, which so often afflict him. This study has been mindful of the areas where the community as well as state mental hospitals could be helpful as well as areas in which the aged have been allowed to flounder.

A recent position statement of the Mental Health Association has taken a similar stance: It advocates a focus which identifies the needs of older people. An excerpt from this statement follows:

The Mental Health Association should familiarize itself with the existing standards and guidelines (federal, state, local and professional associations) for institutions for the care of the aged mentally ill, evaluate these guidelines carefully and make every effort to assure that the institutions provide high-quality programs which meet the medical, psychological, and related needs of these patients. To this same end, the Mental Health Association should encourage the closest possible working relationship between such facilities and the Community Mental Health Centers.²

In developing such a coordinated program for the aged in Maryland, it was considered appropriate to look to a theoretical model which would permit a more focused study. This study was guided by certain community mental health concepts useful with many different populations both in the community and in hospitals.³ These concepts provided the focus for some of the questions in interviews with persons knowledgeable about services in

hospitals and the community. Also, with this framework, it was possible to approach the information provided by case records in an integrated fashion.

Mental Health: Mental health is not viewed in this study as a function of personality alone.⁴ Rather, this study includes an appreciation of the older person's capacity to function in social situations. Thus, the concept of mental health includes both personality and situation. This view emphasizes the person's functioning in crucial life roles and how, as these roles change in the course of aging, the person is able to adapt to new situations, new surroundings, and to actual or potential opportunities. Another factor considered in this view of mental health of the older person is deteriorating physical health.

It has been well established, especially for older persons, that there is a relationship between mental and physical illness. In one study, for example, it was found that older patients in a mental hospital were considerably sicker physically than older people in the community.⁵ The physical health of the older person must therefore be constantly kept in mind in any community mental health approach and in services provided by a hospital for the mentally ill. The medical component should, however, not be overemphasized to the exclusion of other factors, as it sometimes tend to be.

Target Population: The notion of target population is implicit and explicit in the concept of a catchment area. This study, focused on persons 65 years old and older, is an example of the target population approach. Keeping track of a large population in a catchment area simplifies administrative tasks, helps avoid duplication, and makes it easier to be mindful of the accessibility of services important to the aged.

In this study, a target population of those 65 and over was necessary as a unit of attention because, as the Preliminary Report of the Governor's Commission on Nursing Homes has noted,⁶ there are a number of gaps in the approach to services for the older person. Thus he or she is often overlooked by inclusion in other categories such as the poor, the ill, the socially disadvantaged, and other at risk populations. This is not to say that these are not all problems. Poverty, to cite just one example, is a severe problem. In 1970, in Maryland, 16.3 percent of all families headed by persons 65 and older, and 47.1 percent of unrelated individuals 65 and over had incomes below the poverty line.⁷ An additional perspective of the notion of target population to which reference will be made later, is that it affords focus on a population at risk in a hospital and, within this population, on sub-groups such as those 85 or older, or alcoholics.

Continuity of Care: The concept of a continuity of care has been misused in community mental health often being misunderstood to mean life-long dependence on a mental hospital. This is crucial to older persons who have been particularly vulnerable to stubborn adherence to a "custodial philos-

ophy" which has only recently given way to a more positive view about the adaptability of the aged. Continuity of care, as seen in the study, accents the hospital's responsibility to the former patient. This responsibility however is not necessarily most effectively discharged by direct service by the hospital to the former patient. If the goal of services to the former patient is, as it should be, the restoration of the individual's competence in crucial life roles, these services must be provided in collaboration with a number of public and private agencies. Moreover, community mental health centers and local departments of public health and social services share this charge to maintain an acceptable standard of well-being for every citizen. This orientation made it necessary at times to go beyond hospital walls for data.

Gradualism: The concept of gradualism is closely related to the notion of continuity of care in its accent upon various levels of care to which the older person must have access. Such access to a variety of services and an appropriate level of care is necessary to avoid hospitalization, re-hospitalization, and to shorten a hospital stay when admission is necessary. As noted in a previous study, the idea of a certain level of care has been recognized in medically oriented placement facilities such as nursing homes, which have heretofore dominated the scene.⁸ The idea of levels of care is less recognized in homes, which should, in addition, be socially oriented or primarily socially oriented, often without need for a complex array of medical services. Thus the older person should be helped as much as possible to live in his own home or with his family.

When that fails, there should be an array of services available leading to hospitalization or a nursing home as the last resort. In the hospital there need to be appropriate levels of care to minimize regression. At the same time discharge planning must proceed, keeping in mind the appropriate services needed upon discharge. Moreover, when the patient is discharged the cycle of needed levels of care begins anew with the progression, hopefully, from an institutional or semi-institutional setting offering a high level of social and medical care to one offering increasing opportunities for more independent living.

Prevention: The preventive thrust of any program in the mental health field may be described in terms of its emphasis on primary, secondary, and tertiary prevention.⁹ Caplan's explications of primary and tertiary prevention are particularly helpful because of the community-based nature of the intervention strategy that is proposed. On both the primary and tertiary level, Caplan puts emphasis on the provision of basic physical, psycho-social, and socio-cultural supplies needed to maintain mental health. With respect to the aged, the importance of the medical component of these physical supplies should be underscored. Services should be available as community resources such as progressive nursing homes and homes for the aged, other

types of community placement facilities, and/or alternative living arrangements and collateral services to prevent the complete loss of personal autonomy and integrity. More specifically, the range of services which would help maintain the older person in the community, either to obviate hospitalization or to prevent re-hospitalization should consist of opportunities such as day-care, transportation for needed services such as medical care, visits by public health nurses, and other kinds of help when an older person is home-bound. In this category are homemaker services, legal services, housing and, in general, self-support services to help the older person function in the community at his highest possible level.¹⁰ Thus primary and tertiary preventive services are geared primarily to keeping the patient out of the hospital and functioning as well as possible in the community.

Secondary prevention refers to situations where a problem has developed to the point that immediate intervention is needed. This may be done by hospitalization in designated beds in the community or longer hospitalization in a state hospital, when necessary. In secondary prevention the emphasis is on minimizing the regression which so often occurs, especially with older persons, when they are hospitalized. The idea is to short-circuit the beginning of an institutionalization syndrome when patients remain in hospitals longer than they should. With the foregoing as backdrop, this report will now turn to the methodology of the study and the findings.

II. METHOD OF STUDY

The approach in this report is that of a limited field study. The data is from case records in state mental hospitals and from personal visits, observations, interviews, and discussions with selected persons involved in services or planning for the aged in hospitals and the community. The sources of data for this study may be categorized as follows: (1) This study involved a careful scrutiny of the case records of recently admitted patients in all the regional hospitals for the mentally ill.¹¹ Particular information, pinpointed by the Coordinator of Services to the Aged in the Department of Mental Hygiene, was sought. This information pertained basically to certain demographic variables and to social, psychiatric, and mental indicators which characterize patients admitted to regional hospitals for the mentally ill. The records were read with due respect for the pitfalls inherent in records not specifically designed for research purposes.¹² Because it was obviously necessary to limit the number of records read in the short period allotted for the study, it was decided to read a sample of cases in all four hospitals. In order to obtain data as up-to-date as possible, it was decided to concentrate on recent admissions.

A sample was selected of 56 recently admitted patients, a group for which data is difficult to obtain from other sources such as the Maryland Center for Health Statistics. A random selection of 14 patients was made from the February 1972, and April 1972, admissions. Except for Eastern Shore State Hospital, in which all the admissions for February and April, except one, were read, the procedure followed in the other hospitals was that, after a random start, every second or third record was read, depending on the number of admissions. This procedure was pursued diligently to avoid situations where records most easily accessible might be provided for study. April records provided a selection of the most recently admitted group for whom records were complete. Patients admitted in February permitted some perspective on the patient's first four or five months of hospitalization.

In each hospital, after the records had been read, staff members were consulted so that they could comment on the representativeness of the findings. A slightly lower ratio of alcoholic patients in February and April was pinpointed in this way and, consequently, it became an important area for further consideration.

Because most hospitals are somewhat decentralized, a considerable amount of "record chasing" took place.¹³ Except for two hospitals in which it was necessary to randomly substitute a record for one previously selected, all records could be located. The consequent visits to various wards proved to have a positive effect: It was possible to meet many of the physicians, social workers, and nurses intimately involved with the patients in the study. The items in patients' records which received attention will not be detailed in this section. With their rationale, they will be noted in the findings.

(2) The second major data source was interviews, where hospital staff were consulted to explain, amplify and verify information in the records. These interviews also provided leads about programs in operation or planned. In a number of instances, the writer was sought out by staff members who wished to present their ideas because they believed this study and the ameliorative steps which could ensue were important. In all hospitals the superintendents or clinical directors were consulted, in addition to the chief social workers. They, in turn, suggested other key personnel who should be interviewed. In addition to interviews within the hospital setting, there were interviews with persons in crucial roles in after-care services or community services with a preventive focus. Thus, two nursing homes, a domiciliary-care facility and two community mental-health centers were visited. The persons and facilities in the community were determined by whether the resulting data would add needed perspective.

(3) The third major source of data was documents and reports prepared in the hospitals and the Department of Health and Mental Hygiene. For example, data from the Maryland Center for Health Statistics was used, especially where it complemented information from the case material. Reports which detailed situations pertaining to the sample of patients were also scrutinized. Finally, literature on aging and mental health, newspaper reports, and recently published material on the aged in Maryland was read.¹⁴

III. FINDINGS

In this section the findings of the study of the case records of 56 older patients admitted to the four regional hospitals in February and April 1972, will be presented. Initially, data from the Maryland Center for Health Statistics will be offered as a backdrop: *Resident Patients*: Table 1 summarizes in a striking way the situation in Maryland of resident patients 65 and over, and it offers for perspective, the record of previous years. In essence, it shows that while the total patient population has steadily decreased, the proportion of patients who are 65 and over has remained stubbornly high, declining only slightly. On the positive side, there were decreases in the census of patients over 65, a decrease that has kept pace with the decreases in the number of all other patients. Nevertheless, the fact remains that from its highest level, 32.6 percent in 1967, the proportion of patients 65 and over in the following five years never went below 31.1 percent. Although the figures for 1971 are not cited because they were not yet available, it is not expected that they will differ much. With the proportion of aged in Maryland estimated at 7.6 percent of the population,¹⁵ it can readily be seen that state hospitals are shouldering a heavy responsibility.

As for differences among the hospitals, the main feature is that the Eastern Shore patient population has, during all these years, consisted in large measure of patients 65 and over. The lowest ratio of elderly patients was to be found in Crownsville. The other two hospitals were near the average for the state.

It is thus apparent that state hospitals must be equipped to deal with problems of aging because, right or wrong, these problems are stubbornly brought to their attention. Yet, despite some exemplary programs, sheer numbers have made it difficult to reduce the proportion of older patients.

Admissions: In the review of admission figures, it should be mentioned that the writer's stance was not necessarily that a reduction in the proportion of older people admitted is good and an increase bad. Any appropriate admission is obviously a good admission (Appendix A).¹⁶

Table 2 reveals that 5.7 percent of all admissions in 1971 consisted of patients 65 and over. On the face of it, this showing is good in context of Maryland's population over 65, which is estimated at 300,000+ or 7.6 percent of the population.¹⁵ Thus it does not appear to be the admissions ratios which are disproportionate but the resident ratio. In other words, once the older person is admitted, he or she tends to remain in the hospital. Admission rates for older persons, as a proportion of total admissions, have decreased consistently through the years so that they more nearly reflect the proportion of elderly in the population.

Comparisons among hospitals are difficult in view of the varying therapeutic and administrative emphases. It is clear, however, that Eastern

TABLE 1. Resident patients* 65 and older and total resident patients in Maryland regional mental hospitals, June 30, fiscal years 1967-1970, and May 31, 1972. (Prepared by: Maryland Center for Health Statistics, July, 1972. Statistics for 1972 added by the author.)

Facility	Fiscal Year				1972#
	1967	1968	1969	1970†	
Crownsville:					
Residents 65+	384	375	385	303	208
Total residents	1,625	1,545	1,398	1,339	951
Percent residents 65 and over	23.6	24.3	27.5	22.6	21.9
Eastern Shore:					
Residents 65+	291	253	255	223	197
Total residents	523	483	480	440	401
Percent residents 65 and over	55.6	52.4	53.1	50.7	49.1
Springfield:					
Residents 65+	1,047	1,014	941	867	783
Total residents	3,014	2,942	2,863	2,750	2,441
Percent residents 65 and over	34.7	34.5	32.9	31.5	32.1
Spring Grove:					
Residents 65+	688	732	772	709	649
Total residents	2,230	2,368	2,340	2,238	2,065
Percent residents 65 and over	30.9	30.9	33.0	31.7	31.4
All facilities:					
Residents 65+	2,410	2,374	2,353	2,102	1,837
Total residents	7,392	7,338	7,081	6,767	5,858
Percent residents 65 and over	32.6	32.4	33.2	31.1	31.4

*Patients in the hospital on the specified date. Excludes patients on long-term leave.

†Preliminary data—not yet released.

#For May 31, 1972. This data was given to the Governor's Commission on Nursing Homes directly by the State mental hospitals.

TABLE 2. Patients 65 and older admitted to Maryland regional mental hospitals and total admissions, actual and projected, fiscal years 1967-1972. (Prepared by Maryland Center for Health Statistics, July 1972. Statistics for 1972 added by the author.)

Facility	Fiscal Year				
	1967	1968	1969	1970	1971* 1972†
Crownsville:					
Admissions 65+	228	218	259	180	230
Total admissions	3,411	3,695	4,385	4,739	4,920
Percent admissions 65 and over	6.7	5.9	5.9	3.8	4.7
Eastern Shore:					
Admissions 65+	190	195	188	186	195
Total admissions	644	628	721	798	906
Percent admissions 65 and over	29.5	31.1	26.1	23.3	21.5
Springfield:					
Admissions 65+	312	320	288	256	254
Total admissions	3,366	3,499	3,986	4,169	4,491
Percent admissions 65 and over	9.3	9.1	7.2	6.1	5.7
Spring Grove:					
Admissions 65+	203	276	313	214	230
Total admissions	3,211	3,690	4,475	4,356	5,548
Percent admissions 65 and over	6.3	7.5	7.0	4.9	4.1
All facilities:					
Admissions 65+	933	1,009	1,048	836	909
Total admissions	10,632	11,512	13,567	14,062	15,865
Percent admissions 65 and over	8.8	8.8	7.7	5.9	5.7

*Preliminary data—not yet released.

†Data based on January-June 1972 rates and doubled.

Shore again admits by far the highest number of older patients. Yet, at Eastern Shore, the proportion of older patients admitted has gone down appreciably since 1968.

In terms of trends, the most noticeable changes seem to be between 1969 and 1970 and between 1971 and 1972. The reduction in 1972 may, perhaps in part, be attributable to emphasis on services to the patient in the community prior to hospitalization.¹⁷ It is difficult to account for the changes between the years 1969 and 1970, although staffing patterns may be partly responsible. Thus an emphasis on staffing geriatric programs in 1969 could be discerned in one hospital where six additional psychiatrists and other staff were assigned to the medical-geriatric unit during November 1969.¹⁸

TABLE 3. Patients 65 and older admitted to Springfield, Eastern Shore, Crownsville, and Spring Grove state mental hospitals (January 1-June 30, 1972).

	Springfield	Eastern Shore	Crownsville	Spring Grove	Total
January	22	14	17	16	69
February	14	5	21	17	57
March	25	11	29	20	85
April	16	9	20	11	56
May	16	17	21	16	70
June	14	12	13	10	49
Total	107	68	121	90	386

Table 3 is intended to complement Table 2 by affording closer scrutiny of admissions during the first six months of 1972. The figures are the most recent available from the medical records department of the hospitals. The table, additionally, contrasts February and April admissions with other months, an important consideration in terms of the sample's representativeness.

On the whole, the months selected for special attention—February and April—are not unrepresentative; for all the hospitals, these months were neither the highest nor lowest in admissions. For example some of the staff in the admissions departments informed the writer that inclement weather might have made admissions higher in December and January. It was also suggested that the festive season might increase the admissions of alcoholics, and indeed, it was found that December 1971, and January 1972, admissions were somewhat higher than February and April. The highest admission rate in three of the four hospitals, however, was in March. Variations in admissions for alcoholism will be explained in a subsequent section.

In terms of differences among the hospitals in the January to June period, Crownsville apparently received more geriatric admissions in the six months, even though its resident population is the smallest except for Eastern Shore. The burden falling upon Eastern Shore Hospital is again illustrated. Clifton

T. Perkins State Hospital is not cited because its admission of patients 65 and over is small in relation to the total. A hospital for mentally ill offenders, it had only one resident patient over 65 on July 1, 1972.

Patient Movement: A more global impression of patient movement, including admissions and discharges, is offered in Tables 4 and 5. More specific illustrations, based on data from the sample, are provided subsequently.

Table 4 illustrates clearly that the admissions ratio consistently exceeds the direct discharge ratio for the elderly. It also confirms what has long been a truism, that the older the patient, the more difficult it is to release him into the community, especially on a direct discharge. This means that the community is assuming a greater share of responsibility for the patient under 65 than it is assuming for the patient over 65.¹⁹ If a patient had not been discharged by the time he was 74, he may well die in the hospital. Also,

TABLE 4. Number of geriatric admissions and discharges as a proportion of total admissions and discharges: five state mental hospitals*, fiscal year 1970. (Note that the discharge figures are "direct" discharges. Patients often live outside the hospital on convalescent or long-term leave before direct discharge. Information compiled from Maryland Center for Health Statistics Reports.)

Age (years)	Admissions		Discharges	
	No.	%	No.	%
65-74	536	3.7	404	2.9
75-84	225	1.5	118	.9
85+	76	.5	34	.2

*Crownsville, Eastern Shore, Springfield, Spring Grove, and Clifton T. Perkins. Clifton T. Perkins contributed only four admissions and one discharge in fiscal 1970.

TABLE 5. Movement of patients age 65 and over, July 1, 1971-September 30, 1971, at Crownsville, Eastern Shore, Springfield and Spring Grove state mental hospitals. (Data provided by medical-records librarians and compiled by Helen Padula, coordinator, Services to the Aged.)

Movement	Crownsville	Eastern Shore	Springfield	Spring Grove	Total
Admitted	62	57	68	65	252
Became 65 in hospital	5	0	21	5	31
Return from long-term leave	10	23	19	12	64
Total	77	80	108	82	347
Placed on long-term leave	32	30	38	34	134
Direct discharge	31	7	37	32	107
Death	14	28	27	22	91
Total	77	65	102	88	332

many patients, some of them quite sick, reach the age of 65 while in the hospital.

Additional insights about admission and discharge ratios are provided by statistics from the Maryland Center for Health Statistics. These statistics, not detailed here, concern "age-specific" admission and discharge rates and essentially support the data presented. They reveal that discharge rates improved 7.6 percent for the 65 to 75 age group between 1954 and 1970, which is proportionately much less improvement than the discharge rates for all ages combined. Discharge rates for all ages combined between the years 1964 and 1970, no doubt reflecting an "easier in, easier out" philosophy, improved a staggering 92.5 percent. As for the age group 85 and over, that category actually showed a decline of 31.1 percent in age-specific discharge rates during these years.

It should then also be added that, in terms of a target population, the age group 85 and older cannot be neglected. They need considerable care in hospitals, and nursing home placements for them are difficult to find. There is perhaps a natural and humane reluctance to discharge a patient that old from a place where he may have found acceptance. Yet admission rates for the very old patients are considerable, and to this figure are added those who reach 85 in the hospital. In 1970 there were 76 admissions of patients 85 and older out of a total 837 geriatric admissions, or a little under 10 percent.

Table 5 complements the discharge data. On the positive side, the figures for July through September 1971, point to what might be termed net admissions and discharge rates, which are similar. There are slightly more patients coming in than patients leaving, but over a period of years, it appears to have been sufficient to build up the resident population of geriatric patients to an unacceptable level. Both Springfield and Crownsville State Hospitals equalled or exceeded the proportion of patients discharged in relation to those admitted, without an unusually high death rate.

In terms of the specific categories of patients cited, it may be appropriate to mention these briefly. Thus, there are the patients who become 65 while hospitalized. These patients are often the chronic "institutionalized" patients who may have been in the hospital for many years. Then, there are those who die in the hospital. Eastern Shore State Hospital, no doubt because of its many very old patients, contributed a substantial number to the total of 91 patients who died. The latter statistic would be a fruitful area for further study particularly as it relates to the moving of patients to and within hospitals. This question has received attention²⁰ and will receive further attention when the sample is examined. The third category of patients highlighted are those who are placed on *long-term leave*. Patients on long-term leave are in effect discharged from the hospital; i.e., not carried on the hospital census of resident patients, but officially retaining their status as patients. There are both administrative and therapeutic reasons for this

despite the controversial nature of such a category.²¹ For example, some hold that long-term leave status is contrary to sound principles of community mental health because it perpetuates undue dependence by the patient upon the hospital. The writer saw indications that patients on long-term leave tend not to be followed up by community facilities when perhaps they should. Sometimes the hospital cannot extend itself to the degree needed, and when this happens the patient may be consigned to a sort of limbo where neither hospital nor community is clear about their relative responsibility. Until proper community facilities become operative, however, this category may well have to be continued.

TABLE 6. Sex and ages of 56 patients admitted to Springfield, Crownsville, Spring Grove, and Eastern Shore State Mental hospitals in February and April 1972.

Age group (years)	Springfield		Crownsville		Spring Grove		Eastern Shore		Total	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65-69	6	3	5	1	4	2	0	1	15	7
70-74	2	2	2	1	3	3	1	0	8	6
75-79	1	0	0	1	1	0	1	2	3	3
80-84	0	0	0	0	0	1	0	2	0	3
85+	0	0	2	2	0	0	3	4	5	6
Total	9	5	9	5	8	6	5	9	31	25

TABLE 7. Average age of 56 patients 65 and over upon admission to state mental hospitals, February and April 1972.

Hospital	Average age (years)	
	Male	Female
Springfield	68.9	68.8
Crownsville	72.3	78.4
Spring Grove	70.5	70.4
Eastern Shore	82.0	81.3

Sex and Ages of Recently Admitted Patients: These data focus more specifically on the patients studies and in greater depth. All the patients were 65 years or older, and all had been admitted in February or April 1972 to Springfield, Crownsville, Spring Grove, or Eastern Shore.

In Table 6 information is presented which clearly shows the preponderance of males in the sample despite their fewer number in the population.²² It thus appears that the community more easily integrates older women or that they have fewer problems adapting than men. More likely, however, all these and other factors may be tied up with lack of community supports, which is associated with higher hospitalization rates.²³ Why men should be the primary victims may well warrant further study.

An additional factor in Table 7 is that even though males outnumbered females, there was little difference in age once admitted. The exception is Crownsville, where females tended to be older as well as more numerous. Eastern Shore's patients are considerably older when admitted than patients admitted to other hospitals and this is consistent for males as well as females. Perhaps communities on the less industrialized Eastern Shore have greater tolerance for older people than other communities in Maryland.²⁴

Races of Recently Admitted Older Patients: Eleven of the 56 recently admitted patients who were at least 65 years old were Negro and the other 45 were Caucasian; their distribution among the four hospitals is in Table 8 which reveals negligible differences in admission ratios of Negroes and Whites. The number of Negro admissions reflects the proportion of Negroes living in the cities and rural areas of Maryland.²⁵

TABLE 8. Race of 56 patients age 65 and over admitted to four state mental hospitals February and April 1972.

Hospital	Race	
	Negro	Caucasian
Springfield	3	11
Crownsville	2	12
Spring Grove	3	11
Eastern Shore	3	11
Total	11	45

Baltimore, according to the 1970 census, had a population of some 900,000, of whom 46.4 were black, which suggests that the proportion of Negroes admitted is inordinately low. It was found, however, that, in fact, Negroes were over-represented in total admissions: Negroes 65 and over in 1970 constituted 5.6 percent of the total population, but almost 20 percent of the geriatric admissions. The black geriatric patient thus presents a suitable target population for prevention.

No other differences attributable to race could be discerned, although such a generalization would require a larger sample. Negroes and whites were similar in age when admitted; their living situations in the community appeared similar, as were their admitting diagnoses. No other minority groups such as Spanish-American or Oriental appeared in the sample, which probably is a chance occurrence consistent with their number in the Maryland population.

Type of Admission: The rationale for studying the type of admission was that preventive intervention, at least of a consultative or educational nature, might be implemented at the referral source if it were known. Thus judges or

physicians who may be instrumental in admissions could be helped in reaching appropriate decisions. Also voluntary patients can be helped in deciding for themselves whether hospitalization is the best move. It appears that voluntary patients frequently sign in and out of hospitals so precipitously that there is not sufficient time to make arrangements in the community that might make their adjustment easier.

TABLE 9. Type of admission of 56 patients age 65 and over to four state mental hospitals, February and April 1972.

Hospital	Two certificates	Voluntary	Court
Springfield	12	2	0
Crownsville	10	3	1
Spring Grove	9	4	1
Eastern Shore	10	3	1
Total	41	12	3

As Table 9 suggests, most admissions are two-certificate admissions, which means that two physicians, who need not be psychiatrists, attest to the mental illness of the patient and recommend hospitalization. There were only three court admissions, one of whom was an alcoholic with a long history of admissions. The court order was intended to ensure hospitalization long enough for him to receive attention beyond detoxification. An unusual court admission came from a hospital emergency room where, when the person became psychotic, the police were called in. It appears that court admissions are insignificant in number among the aged. One hospital superintendent suggested that court admission for alcoholics might be tested further to see if a longer stay facilitates rehabilitation and interrupts the endless cycle of admission and re-admission that characterizes them.

This study indicates that the alcoholics do tend to enter mental hospitals voluntarily. Of the 12 voluntary admissions, five were alcoholics. The remaining seven were psychotics and one person with organic brain syndrome.²⁶

In summary, it appears that a major burden in admission decisions falls on the physician outside the state hospital and on the patient himself. Almost a quarter of all older persons came to the hospitals voluntarily at least on the face of it. In the records of eight of the 56 admitted patients, no appreciable family involvement could be found which underscores the importance of decision-making by the patient and his physician. Thus the argument for consultation and liaison with physicians and for preventive intervention with the older person himself can be made with some confidence.

Frequency of Admission: It is encouraging to note that more than half of all geriatric admissions were first admissions, suggesting that many older persons

are not the "chronic" regressed patients they are sometimes depicted to be (Table 10). A number of these patients can be discharged within the first few months. Certainly, the high number of first admissions suggests that timely intervention in the community might have avoided hospitalization and could hasten discharge before the patient becomes overly dependent on the hospital.

The largest proportion of first admissions—21 of 34—were diagnosed as having organic brain syndrome (OBS). A number of admitting physicians and social workers said that about half of the OBS admissions, especially first admissions, did not evidence disorientation or pathology sufficient to warrant admission to a mental hospital. A community placement of some kind or supports at home might have been the treatments of choice for such patients.

Those with three admissions or more were primarily alcoholics; eight of the 13 alcoholics fell into that category. One patient was admitted in February for the 45th time and he promptly reappeared in April for the 46th time.

Eastern Shore State Hospital, where the average age upon admission was about ten years higher than in other hospitals, seemed again to reflect the high tolerance of Eastern Shore communities for older people. Eastern Shore had no third admissions.

Ward Assignments: It proved difficult to make generalizations on the basis of ward assignments.

TABLE 10. Frequency of admission for 56 patients age 65 and over to four state mental hospitals, in February and April 1972.

Hospital	Admission		
	First	Second	Third or more
Springfield	5	5	4
Crownsville	9	1	4
Spring Grove	7	3	4
Eastern Shore	13	1	0
Total	34	10	12

Each hospital appeared to have its own system of assignments. What proved to be quite clear, however, was that all the hospitals emphasize thorough physical examination upon admission. The most feasible way to classify the types of wards to which older patients were assigned was to consider them as "geriatric-medical," "regional," and "alcoholic."

At Springfield State Hospital six of the 14 patients admitted (Table 11) were placed in the geriatric service in the Medical-Surgical building. Thus a higher proportion went to the regional or *catchment* areas of the hospital

Aged in Mental Hospitals

TABLE 11. Type of ward to which 56 patients age 65 and over were admitted in four state mental hospitals, February and April 1972.

Hospital	Ward		
	Geriatric-medical	Regional and other	Alcoholism
Springfield	6	5	3
Crownsville	14	0	0
Spring Grove	13	1*	0
Eastern Shore	9	5	0
Total	42	11	3

*This patient was placed in a special ward as part of a research project.

known as *Mens' Group* or *Womens' Group*. Patients assigned to the regional areas usually did not require the close medical supervision typical of those in the medical-geriatric ward. Also, at Springfield, three patients with alcohol problems were sent to a special alcoholism unit. Crownsville's patients are sent to the infirmary for physical examinations, which seems to result in more transfers to other wards during the first six weeks. At Spring Grove, 13 of the 14 patients were sent to one of the geriatric buildings, subdivided into wards, which are said to be well-enough equipped medically to make a special geriatric medical building unnecessary. Transfer of patients to other buildings thus appeared to be minimal within the first six weeks. Eastern Shore State Hospital, reflecting its proportion of very old patients, also relies heavily on the infirmary as the initial ward assignment.

Practices in the various hospitals differ somewhat in terms of initial patient assignments. Regional wards, however, do not seem to be used as extensively for older patients as for the younger; mainly, it appears, for medical reasons. It can be said, however, that medical symptomatology does receive attention and for the aged seems to take precedent over more traditional assignment to a catchment area.

The older alcoholic patient was initially placed in a special alcoholism unit only at Springfield. The clinical director of the alcoholism unit at Spring Grove State Hospital expressed firm conviction about using the resources of that ward for patients with greater rehabilitative potential than those who customarily commit themselves only long enough for detoxification. It thus appears that old alcoholics are not generally given special treatment for alcoholism.²⁷

Major Diagnostic Categories: The classifications of patients by admitting diagnosis proved difficult. In a number of cases diagnosis was deferred or not clearly stated and had to be deduced from subsequent entries in the record. (Hospitals use the American Psychiatric Association Manual for all diagnoses).

The decision to use three major diagnostic categories for this study was

made in the light of observations that there are basically three target populations of aged in state hospitals (Table 12).²⁸ These populations seemed to be (1) psychosis, severe depression, and other severe neurotic or psychiatric disorders; (2) the category which highlights the problems of aging, has in the past been described as *chronic brain syndrome* and more currently is called *organic brain syndrome*;²⁹ and (3) the alcoholic patient, who was most commonly given the diagnosis of *alcoholic addiction*.³⁰

TABLE 12. Major diagnostic categories of 56 patients age 65 and over admitted to four state mental hospitals February and April 1972.

Hospital	Diagnostic Category		
	Psychoses, depression, and other	Organic brain syndrome	Alcoholism
Springfield	4	6	4
Crownsville	4	5	5
Spring Grove	5	6	3
Eastern Shore	7	6	1
Total	20	23	13

There has always been considerable controversy about the charge to state hospitals with respect to alcoholics, revolving around the argument that detoxification, and medical treatment for alcoholics should be provided in the community and that state hospitals should concentrate on rehabilitation programs.³¹ Older alcoholics constituted 23.4 percent of all admissions in the sample. (For a period in May 1971, for which statistics were also available, the figure was about 44 percent). The low number of admissions for alcoholism at Eastern Shore State Hospital may perhaps be explained by the hypothesis that the confirmed alcoholic rarely reaches the age of 80, which is about the average age of admission to Eastern Shore.

To be doubly certain about the data, alcoholic admission rates for other periods were obtained. At Springfield, admission rates for December 1971, and January 1972, were studied, because these two months are considered high-risk due to the holiday spirit and cold weather. In December and January, 14 of 48 admissions (29 percent), to Springfield of persons 65 and over had an alcoholic condition. The Spring Grove rate, six of 26 admissions for May and June 1972, was about 23 percent. In summary, it seems reasonable to estimate that between 20 and 30 percent of admissions of older patients in any one month are alcohol related. The ratio is comparable to national figures.³²

Patients other than alcoholics seem distributed about equally in the other two diagnostic groupings, probably reflecting their overlap.

Medical and Psychiatric Symptoms: Because of the importance of medical symptomatology in the older person, some of it as illustrated in ward

placements and other therapeutic considerations, this information was secured and is presented in Table 13. This data is presented in relation to psychiatric symptomatology.

TABLE 13. Medical and psychiatric symptoms for 56 patients admitted to state mental hospitals, February and April 1972.

Psychiatric Diagnosis	Number of medical symptoms			Total
	One or fewer	Two	Three or more	
Psychosis and other	7	6	7	20
Organic brain syndrome	5	9	9	23
Alcoholism	8	3	2	13
Total	20	18	18	56

The data should be qualified by these considerations. Hospital staffs vary in the degree of attention paid to the recording of medical complaints, especially if the symptom is a common one in aging. Whether a lesser degree of recording of medical symptomatology reflects a lesser degree of attention paid to medical complaints could not be established. Furthermore, by considering medical symptomatology in the context of numbers of symptoms recorded rather than severity, there is an additional hazard.

Another surprising feature pointed out in Table 13 is that alcoholics were, on the whole, seen as having few medical symptoms. It would have been reasonable to expect more medical symptoms in a person with a habitual drinking problem. Perhaps alcoholism as a blanket category encompassed other medical problems which did not warrant mentioning. As for patients with organic brain syndrome, these patients, as expected, were seen as having comparatively high numbers of symptoms. In many situations, so it appeared to the writer, doctors seemed to stop counting. The psychotic and other category was mixed in the amount of medical symptomatology reported.

Eastern Shore State Hospital was particularly meticulous in making note of long lists of medical symptoms upon admission. This may have been a reflection of its older patient population. Thus ten of its 14 admissions were listed as having from three to seven medical symptoms requiring attention. Springfield and Crownsville physicians seemed to be quite variable in the numbers of medical symptoms recorded. Spring Grove seemed to emphasize psychiatric symptomatology and was perhaps less detailed in the recording of medical symptomatology. This, however, is not to say that patients' records contained fewer medical notes, tests, and lab reports than were found in records of other hospitals. One important trend in all four hospitals

was, however, noted: The older the patient, the greater seemed to be the number of medical symptoms.

To complement the information on medical symptomatology, note was also made of whether the patient was ambulatory upon admission. Of the 56 patients admitted, 46 were ambulatory. There was the expected positive association between the non-ambulatory state and a high number of medical complaints. Also, as expected, five of the 10 non-ambulatory patients came directly from general hospitals, a procedure that raises serious concern about the appropriateness and humaneness of transferring patients from general to state hospitals.

Of 56 patients admitted, 20 were described as having one medical symptom, a surprisingly small number when contrasted with the attention paid to the medical components of ward placements. It was found that none of the patients with three or more medical symptoms had been living alone. Typically, patients with many medical complaints were living with relatives or friends or were in a general hospital or nursing home just prior to admission. This finding draws attention to the perils of living alone when there are medical problems, and it suggests a need for public health and remedial services to the person living in relative isolation. Before admission, lack of attention paid to medical complaints appeared to result in dislocation, such as a general hospital admission, and this may result in psychiatric illness.

In essence this study's findings about the extent of medical symptomatology are supported in the literature. The diseases generally found to be particularly critical in older people are heart disease, malignancy, vascular lesions of the central nervous system, influenza and pneumonia, and arteriosclerosis.³³ With the exception of malignancy,³⁴ of which only one case was found, all these medical conditions seemed to be present to some degree in the older patient in the state hospitals studied. No evidence of a pattern of medical symptomatology characteristic of a particular psychiatric population of older persons could be discerned. This is, however, an area worth further study.

Prior Living Situation in the Community: As Table 14 suggests, the largest group of older patients had been living alone, with spouses, with relatives, or a close friend before admission. In other words, they came from non-institutional settings, which points to the urgent need for supportive services for older persons in their homes. The next highest proportion came from general hospitals, suggesting a need for closer liaison with physicians, social workers and nurses in these hospitals, as well as in nursing homes, which contributed eight of the 56 admissions. In fact, nursing homes and general hospitals referred almost 40 percent of the total geriatric admissions in the month of February and April 1972.

Aged in Mental Hospitals

TABLE 14. Living situation of 56 patients age 65 and over before admission to four state mental hospitals, February and April 1972.

Hospital	Living alone	With spouse, relatives, or friends	General hospital	Nursing home	Other
Springfield	2	4	3	2	3
Crownsville	4	5	3	1	1
Spring Grove	2	6	2	3	1
Eastern Shore	3	3	6	2	0
Total	11	18	14	8	5

Although 11 of the 56 patients had been living alone, it was apparent from the records that many had friends or neighbors who cared for them until that burden became too heavy. Often these neighbors were instrumental in the referral to a state hospital or contacting an estranged relative for help.

The low proportion of patients from so-called foster-care placements such as private homes, half-way houses, or other types of boarding homes and community placement facilities was striking. There may be a number of reasons for this. For example, perhaps these community facilities provide the kind of care needed to keep patients out of mental hospitals. Or, perhaps, patients in these situations are referred first to nursing homes and general hospitals which then either return the patient to the community or refer him to the state hospital.

Differences among hospitals were not striking and do not warrant generalizations. Eastern Shore State Hospital, however, consistent with the high age and probable sicker state of the patients it admitted, did admit more patients from general hospitals than from any other community living situation.

Living Situation and Psychiatric Symptomatology: Because of the importance of the living situation before admission and its possible bearing upon psychiatric symptomatology, an attempt was made to see whether a relationship could be discerned (Table 15). The major finding had to do with the older alcoholic. That patient much more frequently than other patients, came directly from general hospitals. Incidental to this, the reluctance of nursing homes to admit alcoholic patients is strikingly illustrated in that no alcoholic patient was admitted directly from a nursing home. A larger than expected number did, however, come from other community placement facilities such as half-way houses. Perhaps, in alcoholism, half-way houses are beginning to have an impact.

Transfers of Patients Within the Hospital: Initial transfers of patients within the hospital must also be seen in the context of the type of ward assignments

made when the patient is first admitted as detailed in Table 11. In Table 16, special attention is given intra-hospital transfers because of the crucial meaning such a transfer can have for the geriatric patient.³⁵

It was found that 27 of the 56 patients were moved from one ward in the hospital to another during the first six weeks of hospitalization. In 11 of these instances the move appears to have been for medical reasons. A patient failing to maintain his health on a ward, for example, would be transferred to the infirmary, patients becoming well would be moved from medical to general wards.

TABLE 15. Living situation of 56 patients age 65 and over before psychiatric diagnosis and admission to four state mental hospitals, February and April 1972.

Living situation	Psychiatric Diagnosis			Total
	Psychoses and Other	Organic Brain Syndrome	Alcoholism	
Living alone	4	4	3	11
With spouse, relatives, or friends	8	8	2	18
General hospital	4	5	5	14
Nursing home	3	5	0	8
Other	1	1	3	5
Total	20	23	13	56

TABLE 16. Initial transfers within the hospital for 56 patients age 65 and over admitted to four state mental hospitals, February and April 1972.

Hospital	Transfers within 6 weeks after hospitalization				
	Infirmary	Regional ward	Geriatric service		
			other than admissions	Alcohol	
Springfield	3	2	0	0	5
Crownsville	0	0	6	5	11
Spring Grove	5	0	0	0	5
Eastern Shore	3	2	1	0	6
Total	11	4	7	5	27

It might be noted that Crownsville apparently admits its older alcoholic patients to a medical service and then transfers them to the alcoholism unit. At Springfield, the pattern seems to be to admit many alcoholics directly to the alcoholism unit. At Spring Grove, both admission and transfer to the alcoholism unit is determined on the basis of rehabilitative potential.

It is, however, apparent that the catchment area concept appears to be less important to the hospitals' assignment of the older patients, since they are less frequently placed in regional wards than younger patients. Perhaps this is

not illogical in view of the fact that the older patient may sometimes have a tenuous relationship with his community or origin. Indeed, it may be more important to eventually discharge such a person into another community which accepts him, rather than the one which may have already rejected him. It is also clear that the presence or absence of medical symptoms is an important consideration in the transfer of an older patient within the hospital.

Dispositions for Older Patients After Admission: A separate analysis was concerned with what happened to the older patients under study in the three- and five-month periods, respectively, between admission and this researcher's visit to the hospital. This data is presented separately for February in Table 17 and for April in Table 18.

It was gratifying to find that hospital staffs were hard at work to return their patients to the community before an institutionalization syndrome could set in. Their achievement was impressive, especially considering the patients' medical problems: Within three months (Table 18) almost half of the patients had been returned to the community; in the five-month period (Table 17) the proportion was even higher, about two thirds. The two tables reveal that the older patient has the best chance of leaving the hospital quickly if he has a spouse, relative, or close friend willing to take him; such placements were particularly high for the three-month period. Arrangements for placement in community facilities such as foster homes, nursing homes and half-way houses—a number of alcoholics came from half-way houses and were returned there—were more difficult to make and apparently either took longer or the patient needed to recover to a greater degree to qualify for this type of living situation. Placements in nursing homes seemed to be as difficult to make within the three-month period as within the five-month period. The staffs reported that, with nursing homes it was a question of filling a bed immediately, which was not always possible. The placements and releases of course did not always work out, but at least the effort was made.

Death is also a part of this picture. Four patients of the 26 admitted in February died within five months; in the three months following April, two died of the 30 admitted. Death in a geriatric patient population is always a real possibility, especially when there is illness such as that found in this study. It appears that the risk of death, for reasons including medical, social and psychiatric factors, is formidable after admission. Contrasted with years go by, however, death is less and less becoming the only way to leave a state mental hospital.

After five months, five of the 26 patients admitted in February were still in hospitals, compared to 15 of the 30 admitted in April; an obvious reason is the time needed to work with the patient and to arrange a placement. However, the record of hospital staffs in making arrangements for the release

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TABLE 17. Disposition of 26 patients age 65 and over within 5 months after admission to four state mental hospitals, February 1972.

Hospital	Died	Nursing home	Other facility	Placement			Total
				Spouse, relative, or friend	Live alone	Still in hospital	
Springfield	1	0	2*	2	2	0	7
Crownsville	0	1	2†	1	1	2	7
Spring Grove	2	0	1‡	2	0	2	7
Eastern Shore	1	0	1‡	2	0	1	5
Total	4	1	6	7	3	5	26

*One alcoholic was returned to a half-way house where he stayed only 3 months before readmission. A second patient was placed in foster care

†One alcoholic was returned to a mission. A second was placed in a boarding home.

‡Half-way House for alcoholics

#Transferred to Deers Head Chronic Diseases Hospital

TABLE 18. Disposition of 30 patients age 65 and over within 3 months after admission to four state mental hospitals, April 1972.

Hospital	Died	Nursing home	Other facility	Placement			Total
				Spouse, relative, or friend	Live alone	Still in hospital	
Springfield	0	0	1*	2	0	4	7
Crownsville	0	0	1†	1‡	2**	3	7
Spring Grove	0	0	0	3	0	4	7
Eastern Shore	2	1	0	2‡	0	4	9
Total	2	1	2	8	2	15	30

*This patient was an alcoholic who had been living with his wife who no longer wanted him

**Both these patients were alcoholics. One signed himself out after two days but was readmitted shortly thereafter

‡This patient was readmitted rather quickly when the relative could not cope with him.

†Transferred to Mt. Wilson Hospital

#One patient was readmitted 6 weeks later

of patients soon after admission is on the whole creditable. Still, there are always a number of patients who remain mentally or physically ill for a time. Also, there are those for whom it is difficult to find a place in the community when discharge would otherwise be possible—and it is these patients who account for the fact that about one third of all state mental hospital patients are 65 and over.

In terms of discharge dispositions according to diagnostic entities, the most striking difference was between the alcoholic patients and the others, for both February and April admissions. None of the alcoholic patients admitted in February were in the hospital by June 30, unless readmitted. Only one alcoholic patient admitted in April still remained in the hospital

two months later. The average length of stay for the alcoholic was about a month. Only one older patient was participating in an identifiable program for the rehabilitation of alcoholics although some others were in alcoholism units for brief periods. Thus it appears that older alcoholics, after they are detoxified, leave the hospital much more quickly than do other older patients. Moreover, discharge planning for them seems to be minimal. Most patients when they leave the hospital live in their own homes, with a friend or a relative. Only two went to half-way houses. In essence, one finds few special provisions for the aged alcoholic other than a program of detoxification followed by a brief period of rest.

To summarize, data on patient dispositions reveals a story of considerable accomplishment. However, there still must be a lot done to engage both patients and the community in sound discharge planning.

Patients' Feelings About Hospitalization: Most of the older patients brought to the state hospitals were in a confused state when admitted. Some were inebriated, some in a stupor, some were so sick that they had to be brought by ambulance, a number were delusional, and others were "uncooperative" and "hostile," which were the comments most often found in records. Very few of the patients were in condition to make a careful rational decision about hospitalization. This also seems to be true of the twelve patients who signed themselves into the hospital voluntarily.

Nearly all patients required the intervention of an interested person or agency in the community in order to reach the hospital, further attesting to the need for community services to help older persons with admission decisions.

The Patient's Family and Hospitalization: It appeared that in most situations it was not the patient's family that was most instrumental in the hospital admission. Indeed eight of the 56 patients admitted appeared to have no family members who were interested. Among these eight were all court admissions. Although records were incomplete in this area—which, in itself is an interesting reflection of how psychiatric considerations seem to outweigh the social—it may be estimated that some 75 percent of the families of patients acquiesce to hospitalization. In only perhaps 25 percent of the admissions could it be determined that they were instrumental in obtaining the necessary physician certificates for hospitalization or in persuading the patient to sign himself in.

The more complete records attested to a pattern of great suffering and frustration by families in their efforts to keep the patients in the community or at home. Hospitalization seems to have represented the last resort in these instances.

Social Isolation: When this research was begun, it was hoped that records would be complete enough to allow a judgment about the extent of social

isolation suffered by the elderly patient at the time of hospitalization.³⁶ It can reasonably be supposed that interested people in the environment may help an older person obtain needed social services and supplies.

As a base for a judgment of social isolation, it had been intended that the following case illustration, taken from a medical record read for this study, would be used as an anchoring point. The case is presented because it appears to represent the situation of a number of patients, if their stories were fully told:

Seventy-seven year old Mr. E. is not atypical of those in circumstances of extreme isolation at the time of admission. He has worked mainly as an itinerant laborer and has lived in nearly every state in the union, retiring in 1948 when he became eligible for Social Security. Since that time he has lived in several rooms or small apartments. He has two siblings but does not know where they are, and says he did not marry because he "wanted to be alone." He is a periodic drinker whose landlady found him otherwise "quite normal" (although he was hallucinating at the time of admission). He had arrived on the psychiatric ward from the county jail where he had been sent for breaking some car windows "because I had too much beer." His diagnoses chronic brain syndrome and alcohol addiction. He appeared not at all unhappy about the prospect of state hospitalization. "It doesn't matter where I am because I keep to myself." He had had no visits except one from his former landlady. Asked whether he corresponded with anyone, he replied, "I never liked people to mix with. I am just reticent."

Rolelessness: In a study of aging in the community, Irving Rosow³⁷ noted that illness, widowhood, retirement or unemployment, and reduction in income were significant indicators of rolelessness and therefore contributed to the aged person's adaptation difficulties:

At Crownsville, all but one patient was suffering in all four areas; i.e., illness, loss of spouse (if married), loss of income, and loss of work.

At Eastern Shore, one patient was a retired teacher with a small retirement income and four others were living with spouses just before admission. These five persons had problems in all other areas; the other patients were worse off.

At Spring Grove three patients had serious illness; two of the three had been with spouses who cared for them as long as they could. As for the other patients, a picture similar to that found in the other hospitals emerged.

The Springfield patients seemed to be slightly better off. Seven of the 14 revealed some positives in the critical areas. The four married patients had been living with spouses when admitted. The fifth man, who was single, was a good salesman who had recently established a routine of excessive drinking. The salesman had a landlady who apparently took him back each time he returned from the hospital, but there was little interest shown in him by anyone else. The sixth patient, still married, had held a job until the age of 73 when he was admitted for the first time with a diagnosis of organic

brain syndrome. The seventh person was in apparent good health but had deficits in all the other areas.

Summary: This section has featured a detailed analysis of the findings in a study of 56 recently admitted older patients in the four state mental hospitals. In the next section, special programs and services in the hospitals and in the community will receive attention.

IV. SELECTED PROGRAMS AND SERVICES

In this section a number of programs and services which have a bearing upon those patients who were admitted or discharged during the period of the study will be reviewed. The analysis will be brief, selective, and, where possible documented. It must, however, be understood that other services exist and omission here is no reflection on their quality. For example, because the primary focus of this study is on a hospital population, such worthy community services for the aged as SAGA (Model Cities), though visited, could not be discussed in detail.

The Patient Evaluation Profile Program: Known as PEPP, this program has been described as a new approach to the delivery of health services in which considerable reliance is placed upon the optimal utilization of nursing personnel. The PEPP program for the aged is located in Crownsville State Hospital. It is a program which features frequent reviews of patients and it conceptualizes such a review in terms of *target problems*, thereby affording a framework for task-oriented activity leading to discharge. The program is mentioned because it focuses on those target problems which are of considerable importance in an aged population. The program's computerized data was a useful source of information.

Target Problems: The target problems of patients in the program are judged by nursing personnel and reviewed in staff meetings. At the end of June, 1971, 78 men and 71 women were residing in the Crownsville geriatric ward. The patients and their primary problems are shown in Table 19.

Medical-physical and social troubles seem to be the major problems of patients and a major concern of the staff. These target problems also pinpoint the corrective services needed. Consistent with this, medical services, social services, including discharge planning, and rehabilitation such as occupational therapy are the services most often sought for patients.

Factors Hindering Release: Another interesting area of concern pinpointed by the PEPP data was the category "factors hindering release" (Table 20).

TABLE 19. Problems of patients in the geriatric ward of Crownsville State Hospital.

Problem	Men (%)	Women (%)
Medical-physical	43.6	48.6
Social	43.6	36.1
Family	5.1	6.9
Legal	3.8	.0
Suicidal	2.6	4.2
Homicidal	1.3	.0
Economic	.0	1.4

TABLE 20. Factors hindering release of 78 men in geriatric ward at Crownsville State Hospital.

Patient Factor	Patient (%)
No community services available	53.0
In-hospital treatment needed	19.5
Awaiting social services	17.9
Awaiting family's cooperation	6.0
Awaiting court disposition	5.1
Other	.0

It appears, according to the judgment of the staff of one geriatric unit, only about 20 percent of the patients were in the hospital because treatment in the hospital was needed. This, of course, raises some question about the other 80 percent. When this information is considered with the large category of patients needing community services such as placement and other supportive services, the magnitude of the problems of the aged in the state hospitals can be appreciated. A corollary here is the high proportion of older persons—almost 18 percent—who, had sufficient social service staff been available, might have received some further attention. One caution is, however, in order: Increase in staff can, it seems, effectively reduce the population of aged only if there is a proportionate increase in community facilities. Finally, the data reported here is consistent with the observations of admitting physicians and social workers: Many older patients would not have to be admitted were community facilities and services available.

Length of Hospitalization: The largest group of patients—57.7 percent of the men and 63.9 percent of the women—had been in the hospital 92 weeks or longer. The next largest group—26.3 percent of men and 15.4 percent of women—had been in the hospital under 29 weeks. Thus, 29 weeks is apparently about the threshold where, if the patient had not been discharged by then, he will very likely be in the hospital longer than 92 weeks. The PEPP statistics thus seem to confirm this study and the observations of the hospital staffs that once regression and institutionalization syndrome develop, it is difficult to reverse the process. This is not to say, however, that patients who had been in the hospital a long time were neglected. Many such patients are released or discharged. The record of the PEPP program seems to confirm national figures suggesting that the vast majority (90 percent) of patients who leave mental hospitals had been there one year or less.³⁸

Types of Release: Of the patients released in the six months before June 30, 1971, 75 percent were released from the program on convalescent leave, whereby the person technically remains on the books of the hospital but is not counted in the census of its patients. The remaining 25 percent of the patients died.

The importance of *convalescent leave* or *long term leave* is thus highlighted and, in this researcher's view, its use should be re-examined. It appeared, for example, that hospitals frequently do not have the staff to follow patients in the community for an extended time, such as six months or a year. This concept of follow-up is also wasteful, because the service might better come from a community-based social worker. It is also inconsistent with the principles of community mental health, since community mental-health centers may pay little attention to geriatric patients when they feel that these patients are receiving services from the hospitals.

In summary, PEPP can be seen as providing useful leads to areas needing further investigation. It clearly points to the need for alternatives in the community to shorten periods of hospitalization. It also seems to confirm what has always been difficult to document:³⁹ In many instances hospitalization is not needed.

The Geriatric Evaluation Services (GES): These are pilot projects created with funds from the Older Americans Act (Title III) and a Community Mental Health Services grant to the Maryland Department of Health and Mental Hygiene. The program is operating in Baltimore City, Baltimore County, and in Wicomico County on the Eastern Shore. One of its purposes is to reduce inappropriate geriatric admissions to state hospitals and to maintain as many older persons as possible in the community. To this end, the program tries to mobilize supportive services and to help with alternative living arrangements in order to avoid hospitalization. This description of two Geriatric Evaluation Services—in Baltimore City and Wicomico County—is not intended to be an evaluation. There were aspects of their activities, however, which seemed directly to affect the patients studies. More specifically, they accounted for fewer admissions than expected in light of previous years. A number of aspects of GES will be mentioned; the data below is based on information provided by the GES in Wicomico County and Baltimore City, and by the state coordinator of services to the aged.

TABLE 21. Admission of patients age 65 and over from Wicomico County to Eastern Shore State Hospital, 1971 and 1972.

Month	1971*	1972†
May	5	3
April	4	0
March	5	1
February	4	1
January	4	2
Total	22	7

*Before the Geriatric Evaluation Service began.

†After the Geriatric Evaluation Services began.

Table 21 details admission statistics for 1971 and 1972, before and after introduction to the GES in Wicomico County. The table illustrates clearly that focusing on a target population in a particular area can substantially reduce geriatric admissions; this result is also seen in the records of patients admitted to Eastern Shore State Hospital during February and April 1972. It will be recalled that most admissions to Eastern Shore State Hospital are directly from general hospitals. In 1972, admissions from the general hospital with which GES had developed a close relationship had decreased substantially in contrast to another general hospital where such a relationship had not been developed. It is important to note this data from Wicomico County, because the achievements of Geriatric Evaluation Services elsewhere may not be fully appreciated due to the fact that they operate in much larger areas, such as Baltimore County and Baltimore City, where a single unit cannot have such a marked impact.⁴⁰

Of the 56 case records from the four hospitals, three were referred by GES. (It is possible, however, that others were GES referred, and that this information was not in the records). A more reliable estimate of the cases GES referred to the state mental hospitals, contrasted with those which apparently bypassed GES, may be seen in the table which follows.

Table 22 illustrates the difficulty in assessing the work of the GES in as large an area as Baltimore City. It is evident that, at the most 19.3 percent of the admissions in any year came through GES. Obviously, the staff of the Baltimore City GES, consisting of a physician and two-to-four social workers or nurses located at Good Samaritan Hospital, cannot be expected to provide total coverage for the Baltimore City, great skill and dedication notwithstanding. Yet the impact of GES upon Baltimore City has been increasing.

The achievement of the GES should, however, not be measured solely on the basis of its capacity to prevent unnecessary admissions to hospitals for the mentally ill.⁴¹ What happens to the patient who remains in the community is equally important.

Table 23 is intended to illustrate what happens to patients who reach the attention of the Baltimore City GES, and for whom disposition had been

TABLE 22. Cases from Baltimore City that were referred by Geriatric Evaluation Service (GES) and admitted to state mental hospitals, as a proportion of total admissions from Baltimore City. (Source: GES, Baltimore City, and Helen Padula, Coordinator, Services to the Aged.)

Year	Admissions from Baltimore City (No.)	GES referred admissions (No.)	GES referred admissions (% of total Baltimore City admissions)
1970	406	33	8.2
1971	341	36	10.6
1972	314	60	19.3

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made at the end of this study. It will be seen that only one-quarter to one-fifth of persons were admitted to state mental hospitals; incidental to this, use of private psychiatric hospitals might be noted. The largest proportion of patients were maintained at home, partly through the intervention of GES. A large number were referred to nursing homes, thus short-circuiting the cycle of state hospital admission, transfer within the hospital, and eventually, perhaps, placement in the nursing home where the patient might have gone in the first place.

TABLE 23. Outcomes of cases closed in 1970, 1971, and 1972 by the Geriatric Evaluation Service, Baltimore City. (Source: Data for 1970 transcribed from GES, Narrative Evaluation (unpublished, 1970). Data for 1971 and 1972 furnished by the GES, Baltimore City, and Helen Padula, Coordinator, Services to the Aged.)

	Year		
	1970	1971	1972
	(N=131)	(N=166)	(N=246)*
Admitted to state mental hospitals	33	36	60
Maintained at home or in other community residence	48	36	70
Admitted to nursing home	27	28	44
Admitted to boarding home /	2	3	5
Admitted to general hospitals	5	12	15
Admitted to private psychiatric hospitals	5	11	10
Maintained in nursing homes or boarding homes from which referred	4	6	0
Consultation only	3	34	39
Other	4	0	1

*Two cases unaccounted for.

Because prevention through home maintenance is such an important alternative to hospitalization, a closer analysis of the group recommended for home care was made. This is offered in Table 24.

TABLE 24. Review of 41 cases (July 1-November 30, 1971) in which Geriatric Evaluation Service, Baltimore City, recommended maintenance at home: outcome by December 31, 1972. (Source: Geriatric Evaluation Service, Baltimore City.)

Outcome	Cases (No.)
Maintained at home	28
Admitted to nursing homes	4
Admitted to state mental hospitals	9
Total	41

It appears that the recommendation to keep the person at home was made in the hope that either GES or cooperating agencies could provide the services needed by the aged person. Table 24 suggests that about two thirds of the patients did remain home for an appreciable time. Sometimes, of course, even when appropriate services are rendered the patient can deteriorate for medical or other reasons. In such situations GES is ready to refer the patient to a hospital or make some other suitable disposition.

The back-up which GES in Baltimore City considered most needed may be seen in the list of services most frequently sought for the 41 patients for whom maintenance at home was recommended: medical follow-up needed, 33; treatment for alcoholism, 5; family-focused social services, 10; housing needed, 6; family members interests, 5; day-care, sitter, 4; home nursing services, 3. There were 22 other services requested, although less frequently than the above.

Summary: It is evident from review of the GES program that unnecessary hospitalization of older persons can be avoided and they can be maintained at home provided certain back-up services are available. The information suggests that a service such as GES can be particularly effective if it does not spread itself too thinly. It also follows that the larger its geographic area of activity the less apparent will be its impact, especially, in a large city such as Baltimore.

The Springfield HIP Grant: Although none of the cases in this study were placed by the Hospital Improvement Program (HIP) at Springfield, it is a program relevant to the concern of this report. The program, which has been tooling up slowly since January 1972, has placed 12 patients in the community. The average number of years these patients had been in the hospital was 1.3 years. Ten of the 12 placements were in *domiciliary care* settings, which are socially rather than medically oriented.

The program attempts to achieve a measure of accuracy in discharge decisions. Consistent with this, the program uses a schedule that emphasizes areas of social functioning which need to be evaluated for discharge decisions. The items on the schedule appear useful and might well be used to evaluate the care, social as well as medical, which the patient would require (The State of Illinois in 1968 adopted a point system using items similar to those on the HIP scale). The items helped determine the placement most appropriate for the patient and a fair reimbursement for the provider of the care. The search at Springfield for an appropriate instrument to measure social functioning in the context of discharge decisions, seems worthy of continued support.

Community Placement Facilities: Community placement might well be the subject of a separate study. (Indeed, the writer made an assessment of such programs and facilities in Chicago after a crisis similar to that leading to the

creation of the Governor's Commission on Nursing Homes. As alternatives for institutionalization in a state mental hospital, when the older person can no longer remain in his own home or with friends or relatives, the following categories of community placements are mentioned.

Types of Facilities

Chronic Disease and Rehabilitation Hospitals: In this category are the three state chronic-disease hospitals, which are not, strictly speaking, community facilities. These hospitals have 848 beds, including 50 skilled nursing-home beds at Western Maryland, which has a total of 248 beds; Deers Head has 284, and Montebello has 266. These hospitals of course, do not serve the aged only. Montebello Hospital in the fiscal year 1970, for example, admitted mostly younger patients: 73.3 percent of its admissions were under 65 years of age.

Skilled Nursing Homes and Extended Care Facilities: The primary function of these homes is skilled nursing care, and many patients in hospital geriatric units, even when no longer mentally ill, are not considered acceptable by these homes. The reasons nursing homes give for their reluctance to accept state hospital patients are many. One reason is that such patients sometimes require a degree of personal care which nursing homes are not willing to offer when they can fill their beds with patients similarly classified, but requiring a lesser amount of care.

Intermediate Care Facilities: These institutions, which are divided into Type A and Type B, do not provide a level of care as high as the skilled homes. The Type B home, providing slightly less care, is a rarity, however. Consequently, patients certified for Type B care may stay in mental hospitals longer than they should.

Domiciliary Care Homes: These are homes which do not require the level of medical supervision necessary in skilled and intermediate homes. The domiciliary home is also a rarity in Maryland, primarily because the reimbursement formula and licensing requirements for these institutions are such that only a well-financed entrepreneur seems to be able to open one and maintain it according to the minimum acceptable guidelines.

The Boarding Home: These homes provide minimum care, mainly room, board and laundry. They are licensed by the Multiple Dwellings Division of HCD rather than the State Health Department.

Foster-Care: Foster family care, as a type of care for the person recovering from mental illness, was pioneered in Maryland. Despite the many positive aspects of this program, it cannot hope to accommodate the large numbers of patients needing placement. Indeed, foster care workers complain that foster

homes are in short supply and that it is increasingly difficult to find them, even in the rural counties where they have been most plentiful.

The Slum Hotel: In this category are the unknown number of unlicensed facilities, where former patients live. Many are substandard, usually supported by funds from the Department of Social Services. These hotels have not been studied in Baltimore, but their existence has been documented in Chicago⁴² and New York.⁴³

Follow-Ups in the Community

Park Hill Nursing Home: It was not the purpose of this study to make exhaustive assessments of nursing homes; however, as an additional perspective, it was useful to visit the nursing home to which one of the patients in this study had been discharged. The home had 52 patients at the time of the visit, which is full occupancy. Of the 52 patients, 15 were from state hospitals, a comparatively high proportion, and were technically on convalescent leave, although there was minimal contact with state hospital workers. As far as the nursing-home administrator could recall, the only personal contact of patients with a social worker within the past three months had been with one from the Maryland Department of Social Services. Still, the administrator believed that with a patient-staff ratio of about one to one, she furnishes adequate care. It did appear, however, that some of the patients, if properly stimulated, could have been more active. Two of the 52 patients were private patients, 15 had been referred by state hospitals, and the others came from general hospitals and other sources in the community. Of the 15 former state hospital patients, 12 were 65 and over. The administrator estimated that no more than four of the 52 patients were under 65.

As for the hardy 88 year old who prompted the visit to the home, she was no longer there. Discharged from the state hospital February 29, she lost consciousness on March 5 and had to be transferred to the emergency room of Maryland General Hospital. She recovered in a week or two, but by that time her bed at Park Hill had been taken by another patient, and she was admitted to Bolton Hill Nursing Home.

The Glasgow Home: The Glasgow Home in Cambridge was visited because it collaborates closely with Eastern Shore State Hospital and accepts many of its patients. On June 16, 1972, 22 of its 32 patients had been residents in a state mental hospital. The ages of the patients ranged from 61 to 96. The home, an Intermediate Type A facility, seemed to provide a pleasant environment for the patients who, it was observed, were given considerable attention by the staff.

Because of the attentiveness of some of the hospital staff, nursing homes on the Eastern Shore were reported to be willing to accept patients they would otherwise reject. A close relationship with the geriatric social worker

existed, providing assurance that if a patient becomes mentally ill in the nursing home, help in re-admission would be forthcoming. In return, the nursing home seemed willing to extend itself to provide services for hospital patients. The arrangement between Eastern Shore State Hospital and the Glasgow Nursing Home demonstrates that a close working relationship between a mental health facility and a nursing home can benefit patients both in the nursing home and in the hospital. However, whether the mental health facility providing the services should be the hospital or the local community mental health center is a question which will receive further attention.

University House: University House, converted from a motel, is among the first licensed domiciliary-care facilities in Baltimore. It was visited for two reasons: (1) Because the advent of such a facility in Baltimore represented somewhat of a breakthrough, and (2) the house was receiving consideration as a possible community setting for the discharge of some of the patients included in this study. Also, news of the facility's existence had evoked considerable interest within the state hospitals.

University House on June 28, 1972, after four weeks of operation, housed 60 residents. There is room in the facility for 300 persons, although it is expected that only the first two floors of the three-floor building will be used for domiciliary-care facilities. Of the 60 residents, 18 were 65 or over, and of these 18 about 14 had been patients in mental hospitals. Thus, there obviously is a demand for such a facility for both the younger and older patients now in state mental hospitals.

The care patients receive is primarily shelter, housekeeping services, board, and help in daily living other than medical care, for which the home is not licensed; the Department of Social Services usually pays the bill. There is a doctor's office in the building and his fees are usually paid for by Medicaid.

The social services at the University House, in the writer's view, should be considerably strengthened. Although the building has some facilities for various recreational activities, it could not be determined whether meaningful recreation or socializing experiences are really offered; The writer was informed that a neighboring social agency, SAGA, had referred some clients to University House. These clients had been in and out of other types of community facilities and now reported they were reasonably happy. The house does employ an untrained "social worker," but much more could be done to link the residents with activities in nearby agencies like SAGA or to encourage agencies to provide both consultation and social services within the home itself.

It is legitimate to question the home's location on the corner of two of the busiest streets in Baltimore. There are also some advantages provided by the location. These are mainly the home's accessibility to nearby agencies and services such as SAGA and University Hospital. Also, it is in an area near

employment opportunities, which could offer some patients an opportunity to leave the home for a more independent living arrangement and to avoid the more usual path of progression to a higher level of care.

It is quite evident that domiciliary type facilities are needed in the Baltimore area. Economic, philosophical and legal considerations dictate that the operation of University House, which is part of a larger chain of nursing homes known as Community Health Facilities, Inc., needs to be supervised closely and without bias against the profit motive that is part of any business endeavor. Responsible persons should try to keep an open mind about this house and should provide the criticism and guidance needed to make it an acceptable part of the system. Public agencies should also come forward with viable proposals for those patients who must remain in hospitals because community facilities are lacking.

Summary: In essence, this account of community placement programs and facilities suggests that much additional work is needed to bring about the range of services and resources needed to make advanced concepts in community mental health become a reality. It did not appear that nursing homes and other community facilities had turned their backs on the former mental patient or the person who, without preventive services, might become one. Rather, indications were that appropriate standards, active liaison, surveillance, and well-thought-out planning were necessary. Reliance on state-sponsored services alone, without regard to the private sector, did not appear to be a viable alternative.

A Hospital Program for the Very Old: The Tawes Program at Eastern Shore State Hospital typifies the difficulties Eastern Shore and other state hospitals have making provisions for old patients with physical infirmities. Some, but not all, of these patients may suffer from the temporary disorientation not uncommon to very old persons. The program housed 145 patients in June 1972, about one third of the hospital's resident population.

The Tawes Building at Eastern Shore State Hospital accommodates men and women, with separate divisions for the lower and upper shores. The average age of patients from the upper shore was 79, and from the lower shore, 78. Patients had been in the hospital from a few months to as long as 43 years; the mean period of hospitalization was about 10½ years. Some who leave the hospital are affluent and can afford a private nursing home arrangement. Efforts are made, however, to discharge all patients when appropriate, although difficulties are encountered in a number of areas. Only about one third of the patients are more or less ambulatory, and nursing homes are reluctant to take these patients because their physical infirmities require more attention than the homes seem able to provide. Yet some patients can be released with assurances that the hospital will provide follow-up services and take the patient back if necessary. Convalescent leave status is used administratively to make this process easier.

The program's social workers believe they provide an accepting home for many patients, and indeed they do. The report however that patients often begin to have difficulties as soon as they are discharged, requiring rehospitalization.

In summary, the program illustrates how difficult it is to discharge old patients with physical infirmities, no matter how fit they are psychologically. Meanwhile, the burden of their care falls upon the state hospital, which may be providing nursing care superior to that in many community facilities. The question remains, however, whether nursing care should be a responsibility of a mental hospital.

The Community Mental Health Centers: In the records of patients admitted in February and April 1972, and the discharge dispositions of those who had left the hospitals, there was little mention of community mental health centers. It was rare that reference was made to follow-up by a community mental health center, and none of the records suggested that a community mental health center had directly referred a patient. Visits and conversations with the representatives of three community mental health centers⁴⁴ in the Baltimore metropolitan area confirmed the minimal role of community mental health centers in the care of the geriatric population.

With the exception of one *geriatric coordinator*, who had only recently joined the staff of the Inner City Mental Health Center, all community mental health centers contacted reported their priorities to be in other areas: Drugs, alcoholism, social problems, and family counseling in general. In common with the staffs of other community mental health centers,⁴⁵ the staffs of these centers preferred to render direct services rather than education and consultation, which should, in theory, be strengthened if community mental health centers are to intervene in the situations of older people in nursing homes and domiciliary-care facilities. At this time, however, the community mental health centers do not appear to be equipped to offer programs of extensive services to the aged. Indeed, the community mental health centers in the Baltimore area seem to rely on the Geriatric Evaluation Services, which are not only located far away, but are not staffed to provide the needed services.

The detailed data which follows was provided by community mental health center staffs. During June 1972, Inner City Community Mental Health Center had 27 patients 65 or over. Provident Community Mental Health Center had 25 geriatric cases out of a total caseload of 1,200; 18 additional cases were open but inactive out of the 300 cases in that category. Catonsville Community Mental Health Center opened 58 cases in May 1972, and closed 21. Only three of these patients were 65 or over. As for Provident Hospital, which has 15 geriatric emergency beds, there were no geriatric admissions between June 1 and July 20.

The above information is sketchy, but it seems to add up to relatively low

caseloads of older patients. Obviously much work remains to be done in terms of planning, coordination, and staff allocation if community mental health centers in the Baltimore area are to help the older citizen. Because of their greater accessibility, a coordinated approach to the aged, cooperatively with the Geriatric Evaluation Services, would appear to be very much needed.

V. ISSUES

The Aged: Whose Responsibility? In Maryland, two major agencies, one public and one private, provide residential care to the aged: The Department of Health and Mental Hygiene, and Community Health Facilities, Inc. The Department of Health and Mental Hygiene in May 1972, was providing in-hospital care for 1,837 aged persons in its four regional state mental hospitals.⁴⁶ Community Health Facilities, Inc., is a public corporation with assets of about \$13 million; it owns about 20 homes, most of them in Maryland, which offer various levels of care. The writer estimates that the number of persons who are 65 and over housed in the corporation's homes in Maryland is also about 1,800 (Appendix B).⁴⁷ It was not possible, within the context of this study, to determine what proportion of nursing home patients were referred by the Department of Mental Hygiene.

It is thus obvious that attention must focus on these two agencies. This report, however, is primarily concerned only with the role of the Department of Health and Mental Hygiene. The issue which appears to be important is whether the care provided is the kind of care needed, which ties in with the question of relative cost, which will be dealt with later. Evidence points to the likelihood that the treatment of choice may often be a community facility costing much less than homes or state mental hospitals.

There is additional cause for concern about the 98 percent of the older population, about 300,000 persons according to the 1970 census, living in the community. There is every reason to believe that, if some of the services mentioned in this report were available, many of those admitted to state mental hospitals could have remained in the community.⁴⁸

Administrative Alternatives

The administrative model most applicable in the provision of services to a target population of aged persons involves a number of decisions which have to do with the centralization or decentralization of administrative responsibility. As Herbert Simon has stated, there are advantages to both centralization and decentralization. Simon notes that coordination, expertise, and control are some of the advantages in centralized administration, but that inappropriate decision-making by persons too far removed from the action is a serious disadvantage.⁴⁹

If an Office of Aging were to be created to provide the necessary coordination, it would have to have adequate funding. There appears, however, to be a pattern in Maryland of creating agencies or departments without the money to reach their target populations with the needed services.

The administrative model should be organized around services in catchment areas, with coordination at the top. Because of the importance of medical care for the elderly, these components would have to be integrated

into a community mental health model. It seems at present, there is a stalemate where neither the community agencies, like community mental health centers, nor the more broadly focused state agencies are fully equipped to render the complex array of services needed—not only personal services but administrative surveillance and standard setting as well.

For administrative models, we can look at the experiences of California and Pennsylvania since 1969. Legislation in both states requires the establishment of county mental health boards and requires the counties to purchase all long-term care provided in state facilities; county expenditures are matched on a 90-10 basis. The legislation is intended to be an incentive for providing local treatment for patients and to discourage the use of state facilities.⁵⁰

Community Mental Health Applications: Older persons who often have difficulty getting about, have a special need for readily accessible services. Thus, the model for service delivery should aim at extending help in the older person's own home; at least, services should be within easy traveling distance. It is reasonably clear that had selected principles of community mental health been observed, a number of the state mental hospital admissions in this study could have been avoided. For example, a high proportion of the patients came to state mental hospitals directly from general hospitals and there is little doubt that some of them could have been referred directly to a more appropriate facility in the community.

The question of service accessibility is especially important given the present relationship between geriatric evaluation services, which are county- and city-wide, and the community mental health centers, which focus on smaller areas. In crisis situations, where speedy intervention is important, responsibility is vital. Local community mental health centers seem to be serving few aged persons⁵¹ and increased emphasis on geriatric services and liaison with agencies serving the elderly is clearly and urgently needed. Moreover, these services should make use of the underutilized emergency hospital beds which are reserved for the elderly patients. Also, day-care programs, some now run by non-DMH affiliated agencies such as SAGA, should be developed in areas where they do not exist.

Particularly important, however, are consultation and educational services, which appear to be almost totally neglected. Thus, consultation and education for staffs of nursing homes and community placement facilities should be provided by community mental health centers and not left solely to social workers from the Department of Social Services, who may not have the time, the authority, the training, or the inclination to render this service.

Issues in the Delivery of Services in State Mental Hospitals

Among the pressing issues in state hospitals is the dilemma of the alcoholic. According to state law,⁵² alcoholics should be treated in state

hospitals when necessary, but they are not to be sobered up there. Although detoxification is by law to be done in a community setting, admission statistics to the state mental hospitals clearly show that detoxification is a primary service of the hospitals. Rarely did the aged alcoholics in this study stay in the hospital long enough to benefit from a rehabilitation program. The result of such little opportunity to do sound discharge planning and follow-up is that alcoholics have a high rate of readmission. The aged alcoholic, moreover, has difficulty finding work and must depend heavily on community resources which offer constructive leisure time activities. He is also thought to be a poor candidate for hospital-based programs for rehabilitation of work habits. It thus appears that planning for the aged alcoholic in state mental hospitals must begin with the first hospitalization (before age 65, if possible), be consistent with planning for all alcoholics, and go beyond detoxification to intervention and liaison with the community.⁵³

A second issue which has bearing on the care which state mental hospitals provide for the elderly is medical care. Discussions with physicians in state mental hospitals indicate that a high degree of medical sophistication is needed in the hospitals even though their main purpose is care of the mentally ill. It appears that a heavy burden is placed on state mental hospitals for the delivery of primary medical services which could be better offered in the community.

A third important issue is the transfer of patients from one ward to another, which may constitute a great upheaval in the patient's life. The practices currently followed would benefit from fuller discussion, and efforts should be made to keep patient movement to a minimum.

A fourth issue needing attention is staffing patterns. Some of the data reported in this study suggests that additional staff is effective in moving more patients from the hospital to the community. This could be seen most easily in one hospital—Crownsville—and chief social workers in other hospitals are quick to argue for bigger staffs. There is, however, a point of diminishing returns when staff is added, especially when discharges must be limited because community resources are lacking. The many examples of remarkable initiative and ingenuity in finding such resources, however, indicates that this point of diminishing returns has not yet been reached.

A fifth issue is continuity of care: How far beyond its walls does the hospital's responsibility extend: The hospital should be encouraged to maintain liaison with community agencies, perhaps even to follow-up some patients. Certainly the hospital staff should avoid becoming as institutionalized as many of its patients. However, these practices do pose the question of how far a hospital's responsibility should extend into the community and at what point it overlaps with the services of a community mental health center. Efforts must be made to avoid a situation in which community

mental health centers do not follow patients because the mental hospitals, at least on paper, assume this responsibility.

In this connection, a re-examination of the category "long-term leave" or "convalescent leave" has been proposed. There is research suggesting that it is not the break in a therapeutic relationship between release from the hospital and follow-up which is crucial. Rather, what counts is the continuity of a relationship, if the patient needs it, with a worker or agency once the patient has been discharged. One answer to the continuity dilemma is to establish close working relationships with community mental health centers and geriatric evaluation services.

Finally, some mention might be made of innovative practices in hospital-based services for the older patient. Some of these services have been described in this report in connection with current programs in some state mental hospitals. However, there are still other areas which might be further explored, as indeed they have been in some parts of the country. One model of care, for example, is brief hospitalization, which could be offered by a community-based hospital working with a community mental health center, as well as by larger state hospitals. Such brief hospitalizations have been found useful with geriatric patients who suffered a recent social or environmental disruption. Another model of service delivery which might well be explored by hospitals, community mental health centers or geriatric evaluation services, is the crisis family therapy approach, whose purpose is to discourage the chronicity and regression which often are a concomitant of hospitalization. This approach places heavy emphasis on services to the patient and his or her family in the community. The current geriatric evaluation services, with their focus on alternative living arrangements and services in the home, seem to have much in common with this method.

Community Placement in Comprehensive Mental Health Planning: Professionals in the mental health field are reluctant to work with the private entrepreneur in the effort to provide resources for community living and ensure that appropriate standards are maintained. Despite the evidence in this study and elsewhere that a number of patients in hospitals could be discharged and that others need not have been admitted had community resources been available, public agencies have not demonstrated a capacity to undertake programs to solve the problems of the large numbers of aged persons who need an alternative to living at home or in a hospital. Without increased involvement of private agencies and private entrepreneurs, there can be little hope of satisfying the demand for the various kinds of community care that are needed. This attitude toward the private sector has permitted abuses to develop when the professionals should have set guidelines, enforced standards and made themselves available for consultation.

There is an urgent need for attention—now lavished upon the medically oriented nursing home—to be devoted in equal measure to the socially oriented home. The appellation of “lesser care facility” so often applied to the socially oriented home, is misleading and does not reflect its importance. Indeed, there is great need for socially oriented homes in Maryland. The great interest—and mixed reception—given to the opening of University House, one of the few domiciliary-care facilities in Maryland, proves the point. The private entrepreneur should not be discouraged from opening a domiciliary facility, *if* he is prepared to provide the services and maintain proper standards. Proper controls are necessary, of course. The alternative to community placement endeavors of this kind seems likely to be continued hospitalization for patients who do not need it, inappropriate placements in nursing homes, and abrupt rather than gradual movement from independent living to hospitalization and *vice versa*.

As for the kinds of services needed in nursing homes and other community placement facilities, some of these, including the social work component, are called for in Medicare and Medicaid legislation.⁵⁴ Particular focus should be on preventive services, some of them consultative, with a view to the appropriateness of the care offered. There is some evidence that many patients continue to live in nursing homes because so-called “lesser care” facilities are not available. For example, one study in Massachusetts indicated that of the patients in the nursing homes surveyed, 27 percent needed some other type of supervised living situation.⁵⁵ Other researchers in the field of geriatrics have pointed out that frequently neither psychiatric hospitalization nor nursing homes are the treatments of choice, but that, rather, emergency services on an out-patient basis and social services of a tangible and supportive nature are badly needed.⁵⁶ Implementation by social workers, physicians, public health nurses and others working in the community of the spirit of existing legislation would contribute greatly to improved standards of care. Moreover, to be effective, it appears that some of the preventive services mentioned should be extended on a local level, with coordination from a centralized source.

Examination of the issues in community placement would not be complete without emphasizing controls and the enforcement of proper standards. The medical emphasis of many of these standards should be complemented by equal emphasis on the social. Also, state and federal officialdom must keep up with the rapid developments in the nursing home field. A system characterized by the sometimes disjointed activities of individual entrepreneurs, for example, has mushroomed into one dominated by nursing home conglomerates (Appendix B).⁵⁷ Even states may not be able to monitor the activities of large corporations without help from federal agencies with whom they should maintain close liaison. For example, the federal government has recently initiated a new program granting federal

certification to nursing homes.⁵⁸ Other federal mechanisms can also be called into place to regulate costs and prices and to control corporate mergers, which could result in subsidization of a corporation's activities in other industries by federal funds paid to the corporation's nursing homes.

Health Services Delivery: This study has highlighted the importance of medical aspects of admissions to state mental hospitals, both as reflected in the high number of referrals from general hospitals and the medical condition of patients when they arrive. Conversations with administrators of large general hospitals in Baltimore makes it clear that there are insistent pressures to discharge patients, especially those disapproved by funding sources, often precipitously, for continued treatment at the hospital. Sometimes it is the physician who orders the discharge of a patient on short notice, without regard to the social planning which must be a part of such a discharge. There is, in addition, a low level of tolerance in some general hospitals for the slightly disoriented or alcoholic older patient. All these patients may eventually find themselves transferred to hospitals for the mentally ill, usually on two-certificate admissions.

Transfer of older patients from community general hospitals to state mental hospitals is a complex problem, in part involving basic medical economics. The often-heard refrain that there is "need for a bed" cannot be a cogent reason in view of the rather low occupancy rates of general hospitals in the Baltimore area. (In fact, in two major general hospitals visited—University Hospital and Good Samaritan—the occupancy rates on a particular day in July 1972, were 65 percent and 56 percent respectively.) Since hospital costs are to a large extent fixed costs (by some estimates 70 percent) it is difficult to understand these pressures for discharging patients precipitously.

Records read during this study attested to much unnecessary distress resulting from the ill-considered transfers of some patients, in critical condition, to state mental hospitals. The practice of transferring patients with serious physical illnesses to state mental hospitals, which lack some of the necessary medical resources, is highly questionable. The situation is further aggravated by under-utilizing or under-staffing of social service departments in some general hospitals.⁵⁹ However, as mentioned, a lower rate of transfer of patients from a local general hospital to a state mental hospital results when a social worker from the Geriatric Evaluation Service is involved.

In summary, the state mental hospitals and community-based agencies collaborating with the Department of Mental Hygiene need to continue efforts to achieve a coordinated, humane, and financially sound approach to the elderly patient who has medical, social, and psychiatric problems.

Federal-State Reimbursement Formulae and Certification for Care: Federal-state reimbursement formulas are currently receiving attention by the Governor's Commission on Nursing Homes. The cost of hospitalization in a state mental hospital is currently \$14.22 a day, and it may well be that the alternative of care in the community, at domiciliary rate of \$7.00 daily, for example, is not only more sound therapeutically but also less expensive.

The Need for Additional and Timely Data: It became clear during this study, that much needed data does not exist. Also, some of the available data was too old to permit reliable judgements about programs. Therefore, much information had to be obtained from case records, a costly and time-consuming procedure.

Although the Maryland Center for Health Statistics proved helpful, even it did not have up-to-date information. For example, some 1970 data about resident patients was available from the center only in a preliminary form (Table 1). Thus, each hospital had to be separately contacted. Were the information easily available on IBM cards, perhaps this situation would improve. It is difficult to plan future programs and evaluate existing ones without up-to-date information.

It should, of course, be understood that detailed information on every conceivable program and target population would be an unreasonable expectation. However, data focused a little more directly on such critical populations as the aged, alcoholics, and disturbed children would no doubt enhance planning for services to these groups.

Illustrative Vignettes: The following vignettes underscore the kinds of situations discussed in this report. The vignettes were selected from material available through the Coordinator on Aging in the Department of Mental Hygiene from case records and from the literature.

- (1) Police picked up a 70-year old confused and disheveled man wandering in the bus station en route between Philadelphia and Richmond. Chronic alcoholic and paretic; cleared up shortly after admission.
- (2) Pulmonary TB patient at VA hospital became confused, disoriented, and occasionally incontinent. He was sent to Crownsville where transfer to Mt. Wilson Hospital was initiated.
- (3) University Hospital sent a 70-year old chronic alcoholic for the third time in one month.
- (4) A 75-year old woman, evaluated by the Geriatric Evaluation Service and Provident Mental Health Center, sent for admission. Multiple possible medical conditions—cancer, thyroid, cataracts. The woman was under pressure caring for a severely retarded adult and bedfast daughter. The daughter was also admitted later. Patient cleared up quickly and released in about one month.

- (5) A 79-year old patient was admitted with a diagnosis of organic brain syndrome. He was uncooperative upon admission. There were multiple medical complaints, apparently heretofore unattended. His medical condition deteriorated and he died two and a half months later.
- (6) A 68-year old deaf person became a management problem for his relatives. After he arrived in the hospital he deteriorated rapidly, and after five months was in one of the more regressed wards of the hospital.
- (7) After an alcoholic had been admitted as a voluntary patient 20 times and always released after a few days, the hospital superintendent determined that this person would not be readmitted without a court order requiring a minimum stay sufficient to introduce the patient to some rehabilitative opportunities. The court order was obtained. This time the patient stayed about three weeks and it was possible, for the first time, for a social worker to become actively involved in discharge planning, including arranging a place to stay.
- (8) A patient arrived in a stupor from a nursing home. Two days later he was on the critical list.
- (9) A depressed, infirm patient age 92 was admitted. Her depression improved sufficiently for her to be placed in a nursing home within a week. She was still there three months later.
- (10) An alcoholic patient was admitted for the 47th time. He was discharged after two days.
- (11) An elderly patient was admitted requiring medical attention for the following: Cysto-urethrocele, fibrosis of the bases, cataracts, partial deafness, endentulousness, GYN problems.
- (12) An example of what can happen when there is insufficient coordination occurred with an 80-year old patient at the Johns Hopkins Hospital:

After a stay in the hospital, it was decided the woman, on public assistance, should be moved to a nursing home or acute hospital.

Required forms listing her diagnosis were sent separately to the City Health Department to determine nursing-home eligibility and to Montebello State Hospital to determine chronic-care eligibility.

The City Health Department turned her down, saying her condition was so acute she should be in a chronic-care hospital. Montebello turned her down, saying she was not acute enough for placement there and should be in a nursing home. The woman is still in Hopkins.

- (13) Finally, the following vignette illustrates what can be done with timely preventive services and the resources to make them effective:

Mr. G., a 65-year old single man, was hospitalized with a diagnosis of heart block. Surgery was performed to insert a pacemaker. The physician referred the case to social

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service because Mr. G. was depressed, cried for long periods, and insisted he could not go home. From a medical standpoint, Mr. G. did not need special nursing. But the worker learned that he had no relatives living in the United States and that he lived an isolated life. He rented a furnished room in an area where he knew few people. After talking to Mr. G. the worker concluded that his emotional condition was precarious. He could no longer live alone without extreme anxiety, which would adversely affect his recovery. The worker arranged for Mr. G. to live in a home for the aged after a period of convalescence in a temporary-care facility.⁶¹

VI. SUMMARY AND CONCLUSION

This report has highlighted the situation in Maryland of aged persons recently admitted to state mental hospitals. It has focused on the social, medical, and psychiatric problems which prompted their admissions. The intent has been to highlight the situations of older patients and to draw attention to issues which need to be resolved if services to the elderly, either in the state mental hospitals or in the community, are to be improved. Consistent with this, attention was paid to principles of community mental health which need to be applied if unnecessary hospitalizations are to be prevented and appropriate releases made from state hospitals.

Particularly striking has been the fact that the aged for a number of years have consistently constituted a high proportion of resident patients in mental hospitals. Community services, which might in some cases have prevented the gradual deterioration of the older person, have been lacking. The dearth of alternatives to hospitalization in a state mental hospital also received attention. Here, the importance of community residential facilities was noted and it was suggested that issues relating to standards and costs, as well as availability of various types of facilities, receive increasing attention. An approach which keeps in view the medical and psychiatric needs of the older person but balanced by emphasis on the social components, is urgently needed.

The solution to the situations discussed in this report are not simple. Solutions can be approached only through informed discussion of the issues involved, followed by sound planning and budgeting. It is hoped that this report has contributed to these ends.

APPENDIX A: ADMISSION GUIDELINES AND CRITERIA

State of Maryland
Department of Health and Mental Hygiene
State Office Building
301 W. Preston Street
Baltimore, Maryland 21201

NEW GUIDELINES FOR ADMISSION OF THE AGED TO STATE MENTAL HOSPITALS

About 2,000 aged persons are cared for at present in the Maryland state mental hospitals. Many of them were admitted in old age for a variety of medical and social needs rather than primarily for psychiatric treatment.

By serving as a substitute for services and facilities unavailable in the community, the mental hospitals are impeded in offering optimum care for those aged who do need psychiatric treatment and provide a poor alternative for those who do not.

To aid the aged, their families, community organizations and referring physicians to make the best use of the state mental hospitals and of alternative resources, if indicated, the Department of Health and Mental Hygiene has established the following:

1. Criteria for Admission of the Aged to State Mental Hospitals (attached).

Recognizing that appropriate alternatives are limited, the Department has deliberately worded the Criteria (except for the section on Clearly Inappropriate) to permit flexibility in working out a plan in the patient's best interest.

2. Modification of Admission Procedure

a. Prior to mental hospital admission, all aged patients (65 years of age and older) from Baltimore City and Baltimore County should be referred for pre-admission evaluation to geriatric evaluation units in the local Health Departments.

Geriatric evaluation teams are functioning in only these two subdivisions at present but will become available in other counties. The evaluation team maintains close contact with the patient's personal physician in making a full assessment (social as well as medical or psychiatric) of the patient in his own home, advising about alternative resources if indicated and assisting those concerned to obtain these services. If mental hospital admission is recommended, the information gathered is made immediately available to the hospital. Wherever practicable, an effort is made to maintain the patient in his own home.

Referral may be made by telephone or, in the case of physicians, by mailing completed form SHD 29 (used for nursing home approval) with accompanying certificate.

For emergencies occurring during evenings or weekends, call the admitting physician at the appropriate state mental hospital.

b. In all other subdivisions, follow established Hospital Admission Procedures contained in the instructions accompanying the physician certificate forms: "The relative, a family physician, or public official who is responsible for the decision to admit the patient to a mental hospital shall first call the Pre-Admission Service of the hospital."

Your cooperation in observing the criteria and modifications in admission procedure is earnestly requested.

James E. Carson, M.D.
Commissioner
Department of Mental Hygiene

State of Maryland
Department of Health and Mental Hygiene
State Office Building
301 W. Preston Street
Baltimore, Maryland 21201

CRITERIA FOR THE ADMISSION OF THE AGED
TO MARYLAND STATE MENTAL HOSPITALS

I. Clearly Appropriate

A. Those with functional psychoses without significant physical illness or disability for whom out-patient treatment is not feasible.

Examples:

1. Patients receiving psychiatric treatment in the community who require brief periods of protection from the consequences of their behavior during episodes of acute disturbance or depression, i.e., suicide, homicide, spending sprees, refusal to eat.

2. Chronically mentally ill patients who require protection and management, as well as treatment, during prolonged periods of disruptive or disorganized behavior, requiring regular and frequent attendance of a physician.

B. Alcoholics without significant physical illness or disability who, following detoxification, need a period of in-patient treatment for their alcoholism.

C. Those with severe organic brain disease whose usual behavior, intractable to medication, is too disturbing to be managed at home or in another facility. Examples: the physically aggressive patient, fire setter, eloper or person otherwise dangerous to himself or others when *physically able* to carry out this potentially destructive behavior.

II. Clearly Inappropriate

A. Those with acute brain syndrome, which is symptomatic of a grave physical illness, requiring urgent admission to a general hospital.

B. Those who are moribund or comatose.

C. Those with major medical problems and minor mental symptoms. Examples: patients who become mildly confused or disturbed as a result of or in conjunction with recent head injury, cardiovascular disease, diabetes, metabolic disturbance, terminal malignancy, etc. Psychiatric consultation might be utilized, if required, rather than mental hospital admission.

D. Those with inconsequential lapses of memory and mild disorientation as a result of chronic brain syndrome are more effectively treated or managed in their own homes, or, if necessary, in a foster home, home for the aged, etc. A state mental hospital has little to offer and, in view of large wards in most state mental hospitals, may aggravate the patient's confusion.

E. Those who need only adequate living accommodations, economic or other social support services.

III. Individualized Assessment

In the following situations, various factors have to be weighed to determine the course of action best suited to the patient's needs. If doubt exists about the etiology of the patient's behavioral disturbance or if he is also suffering from a physical ailment more severe than the mental disorder, admission to a mental hospital should be deferred until a complete medical evaluation is made, if necessary by admission to a general or chronic disease hospital.

Institutions and Long-Term Care

A. Those with reversible psychiatric illness accompanied by serious medical problems may be admitted if the general hospital has no psychiatric ward or other psychiatric service *and* if the mental hospital has the capacity to treat the medical condition.

B. Those with chronic brain syndromes should be assessed in terms of the potential efficacy of psychiatric treatment and management, the degree of behavioral disturbance and the resources of family and social situation.

Examples:

1. During episodes of agitation and restlessness produced by a stress situation, they may require brief mental hospital admission.

2. Those with moderate or advanced symptoms require careful evaluation of their potential for improvement. They are evaluated most effectively in their familiar setting but may, when home factors are detrimental, require assessment in a controlled environment which may be a mental hospital.

3. Temporary admission for senile patients cared for by the family may be considered to provide relief to the family and to permit a comprehensive evaluation of the patient.

In general, family members and referral sources should bear in mind that the patient will remain in the hospital only as long as psychiatrically indicated, namely, while such hospitalization can be expected to benefit the patient by effecting clinical recovery or, at least, symptomatic improvement. Mental hospitalization, like admission to any hospital, is not intended as a permanent arrangement.

APPENDIX B: FINANCIAL REPORTS OF
COMMUNITY HEALTH FACILITIES, INC.

STANDARD & POOR'S REPORT ON COMMUNITY HEALTH FACILITIES, INC.

CYH	Community Health	7551	
Stock—	Price Jun. 9'72	Dividend	Yield
COMMON	11 5/8	None	None

STOCK APPRAISAL: This nursing home operator has recently begun a program of diversification into centers for retarded children and other institutional services. A proposed merger with Western International Corporation was called off in June 1972.

THE COMPANY'S POSITION

Community Health Facilities operates 20 nursing homes with over 2,100 beds and three facilities for the care of retarded children with some 210 beds.

The company's nursing homes are located primarily in Maryland (14), with the remainder in North Carolina (4), Pennsylvania (1) and Delaware (1). Thirteen of the nursing homes are classified as extended care facilities, six as skilled nursing homes, and one as an intermediate care facility. In addition, the company operates a 300-bed domiciliary care residential center in West Baltimore.

Patients are admitted for nursing and extended care subject to the supervision of their personal physicians, and receive room, board, nursing care, drugs and other medical services, such as physical therapy. The company's centers do not have resident physicians, although they do have at least one consulting physician on call and utilize the services of these consulting physicians to advise in establishing medical and nursing policies. A major portion of the company's business is done with chronically ill or convalescent elderly patients who require nursing care and can qualify under the Medicaid program. Over 50% of the company's revenues are derived from Medicaid.

Although the company's centers are not of standard design, they offer substantially similar services, and many administrative functions are centralized. Each center has in effect a transfer agreement with at least one general hospital to expedite the transfer of patients and records.

In late 1970, the company began a pilot daycare program with the opening of a center in Baltimore, Maryland. Management is considering expanding into other institutional services, including psychiatric centers and facilities for treating children with learning and emotional disorders.

Employees: 1,336. Shareholders: 2,011.

RECENT DEVELOPMENTS

Revenues for the nine months ended March 31, 1972 advanced 14.5% from those of the corresponding year-earlier period. Margins narrowed, however, and pretax income declined 8.1%. After taxes at 45.3%, against 42.9%, net income fell 11.9%. Share earnings were \$0.37 and \$0.42 for the respective interims.

Community Health Facilities and Weston International Corp. announced in June 1972, that their proposed merger had been called off. Consummation of the initial merger agreement would have nearly tripled Community Health's annual revenues and expanded operations into transportation leasing, insurance-premium financing and overseas-convention travel.

Institutions and Long-Term Care

DIVIDEND DATA

No dividends have ever been paid.

FINANCES

Substantial portions of the company's revenues are reimbursable under Medicare and Medicaid programs and, as such, are subject to review by various governmental agencies.

CAPITALIZATION

LONG TERM DEBT: \$5,086,363.

COMMON STOCK: 980,631 shs. (\$0.50 par); some 38% owned by officers and directors.

OPTIONS: To purchase 19,900 shs. at \$5.12 to \$13.75 a sh.

STANDARD & POOR'S REPORT ON COMMUNITY HEALTH FACILITIES, INC. EARNINGS AND BALANCE SHEET POSITION

Annual Report—Consol. Inc. Acct. Yrs. End Jun. 30: \$

	1971	1970
Patient revenue	9,620,648	7,836,919
Gen. & adm. exp.	1,647,261	1,386,923
Oper. Exps.	6,537,410	5,303,197
Oper. Income	1,435,977	1,146,799
Other Income	248,662	267,841
Total Income	1,684,639	1,414,640
Depreciation	347,918	289,021
Fed. Inc. tax	381,800	290,500
State Inc. tax	71,500	48,000
Defr. Fed. Inc. tax	cr4,500	cr4,900
Int. & financing exps.	313,778	299,881
Net income	574,143	492,138
*Sh. earns	\$0.59	\$0.50

*Avge. shs. 1971—980,631; 1970—985,756

Consol. Bal. Sheet, Jun. 30: \$

Assets	1971	1970
Cash & equiv.	685,516	2,572,523
Short-term invests.	200,000	700,000
Notes, rec.	13,500	12,000
Accts, rec.	924,828	846,952
Accrued int.	17,008	24,544
Prepayments	287,749	205,455
Total Curr. assets	4,128,599	4,361,474
Investments	219,324	53,837
Note, rec.	32,575	44,000
Unamort. lg. term financing costs	103,115	110,531
Improve. & replace. funds	67,083	47,383
Goodwill	55,547	25,110
Net property	8,147,974	6,314,431
Defr. start-up costs	130,528	106,528
Deferred chgs. etc.	a50,546	a61,041
Total assets	12,925,291	11,124,335

Aged in Mental Hospitals

Liabilities—

Curr. debt. mat.	346,076	271,928
Accts. pay.	234,862	308,649
Medical contractual pyts.	335,025	261,030
Accruals	226,119	158,155
Income taxes	343,167	321,024
Tot. curr. liab.	1,485,249	1,320,798
Long-term debt	5,066,363	4,005,187
Defr. Fed. Inc. tax	17,800	22,300
Defr. credits	22,768	24,176
aCom. stk. p. \$0.50	493,315	493,315
†Treas. stk.	dr54,167	dr41,259
Paid-in surp.	4,224,151	4,224,151
Retain. earns.	1,649,812	1,075,669
Total liabs.	12,925,291	11,124,335
Net wkg. cap.	2,643,350	3,040,678
cEquity per shr.	b\$6.28	b\$5.72
*Depr. res.	1,652,130	1,304,212
†Shs.	6,000	4,000

aIncl. unamort. organization costs

bBef. deductg. unamort. organization costs not separately reported

cExcl. defr. Fed. Inc. tax

eShs. 986,631

TOTAL REVENUES (Million \$)					¹ COMMON SHARE EARNINGS (\$)				
Quarter:	1971-2	1970-1	1969-70	1968-9	Quarter:	1971-2	1970-1	1969-70	1968-9
Sep.	2.74	2.15	1.85	1.33	Sep.	0.15	0.14	0.10	0.11
Dec.	2.82	2.68	2.05	1.36	Dec.	0.11	0.12	0.09	0.13
Mar.	3.03	2.68	2.05	1.35	Mar.	0.11	0.16	0.13	0.13
Jun.		2.36	2.16	1.65	Jun.		0.17	0.18	0.07

¹ Bef. spec. items.

INCORPORATED in Maryland in 1968. OFFICE—1400 John St., Baltimore, Md. 21217. CHRM & PRES—J. B. Francus. SECY-TRES—M. C. Buxbaum. DIRS—F. Abraham, W. T. Azar, M. C. Buxbaum, C. W. Cox, J. B. Francus, H. H. Katz, R. Rynd, E. C. Salontz, H. Wagonheim. TRANSFER AGENTS & REGISTRARS—Equitable Trust Co., Baltimore; Chemical Bank, NYC.

Information has been obtained from sources believed to be reliable, but its accuracy and completeness, and that of the opinions based thereon, are not guaranteed.

Community Health Facilities BULLETIN TO SHAREHOLDERS JUNE 13, 1972

Community Health Facilities had revenues of \$8,594,284 and net income of \$363,051, or 37 cents a share, for the nine months ended March 31 vs. \$7,508,925 in revenues and net income of \$412,059, or 42 cents in the same 1971 period. There were 980,631 average shares outstanding in the 1972 span and 981,075 the year before.

Community Health and Weston International Corp. have agreed to call off the proposed merger of the two companies previously announced on May 16. The decision by both companies was that a merger would not be feasible at this time. No further negotiations are contemplated.

In a major expansion, Community Health has completed the conversion of a five-story facility near the University of Maryland medical complex in Baltimore into a 300-bed

domiciliary-care center. The purchase and conversion of the facility involved approximately \$1.25 million.

The new center, called University House, will provide a protective environment for short and long-term residents, including those requiring only minor medical attention. University House is designed to serve as a kind of halfway house offering a level of services between the person's own home and the comprehensive care of the nursing home facility.

University House, which began accepting patients last week, is the first licensed center of its kind in Maryland. The addition of University House to the Community Health network of institutional services gives the company a total of 24 health-care facilities with nearly 2,600 beds in Pennsylvania, North Carolina, Delaware and Maryland.

REFERENCES

1. Special appreciation and acknowledgement are due Helen Padula, coordinator, Services to the Aged, Department of Mental Hygiene, and to the superintendents and staffs of the state mental hospitals who so freely shared their time and offered suggestions.
2. National Association of Mental Health, Statement, *Ment. Hyg.* (Spring 1972), p. 71.
3. For an application of such concepts to the mentally ill offender, see J. Goldmeier, E. Patterson, and R. H. Sauer, "Community Mental Health and the Mentally Ill Offender," *Maryland Med. J.* 21 (July 1972), pp. 55-60.
4. M. Johoda, *Current Concepts of Positive Mental Health* (New York: Basic Books, 1958).
5. M. F. Lowenthal, "Social Isolation and Mental Illness in Old Age," in *Middle Age and Aging*, B. L. Neugarten, Ed. (Chicago: University Press, 1968), p. 234.
6. *Preliminary Report of the Governor's Commission to Study Problems in Nursing Homes* (Baltimore: Governor's Commission on Nursing Homes, 1972), p. i.
7. R. T. Lansdale and W. D. Bechill, Eds., *Maryland's Older Population*, (Baltimore: Department of Employment and Social Services and Commission on Aging, 1971), part 2, p. v.
8. J. Goldmeier, "Community Placement and Comprehensive Mental Health Planning: Issues and Obstacles," *Community Ment. Health J.* 6 (June 1970), pp. 155-162.
9. G. Caplan, *Principles of Preventive Psychiatry* (New York: Basic Books, 1964), pp. 113-127.
10. Lansdale and Bechill, *op. cit.*, part 4, pp. 100-101.
11. The term "regional hospitals" denotes the four major hospitals serving Maryland: Crownsville, Springfield, Spring Grove, and Eastern Shore state hospitals. The terms "geriatric," "older," and "aged" refer to patients 65 and over.
12. J. Frings, R. Kratoch, and B. W. Polemis, *An Assessment of Social Case Recording* (New York: Family Service Association of America, 1958).
13. I would like to express my appreciation to the medical-records librarians whose assistance in tracking down records was invaluable.
14. See, for example, Lansdale and Bechill, *op. cit.*, parts 1-4.
15. Lansdale and Bechill, *op. cit.*, part 1, p. 21.
16. See Appendix A, Criteria and Guidelines for Admission. It may, of course, be

reasonable to conclude, as will be illustrated later, that had appropriate facilities in the community been available some of the admissions could have been avoided.

17. See subsequent section on Geriatric Evaluation Service.
18. L. M. Stanley, *Outcome of a Team Approach in Providing Services for the Medical-Geriatric Patients at Crownsville State Hospital* (Crownsville (Md.) State Hospital, Social Services Department, 1971 [Mimeo]), p. 1.
19. This finding duplicates a similar one in a study of community placement programs in Cook County, Illinois. See J. Goldmeier, *An Assessment of Community Placement Programs and Facilities in the Chicago Metropolitan Area* (Chicago: Department of Mental Health, State of Illinois, 1967), p. 14.
20. E. Killian, "The Effect of Geriatric Transfers on Mortality Rates," *Soc. Work* 15 (Jan. 1970), pp. 19-26.
21. The State of Illinois had a similar category of patients, the "conditionally discharged." This category was abolished in 1967.
22. Lansdale and Bechill, *op. cit.*, part 1, p. 19. In 1970, three out of five persons age 65 and older in Maryland were females, a proportion that has been increasing since 1890. The sample is quite suggestive about older admissions generally, in that additional data not cited (from the Maryland Center for Health Statistics) reveals that in some of the older age groups the ratio of men admitted is as much as double the ratio of women.
23. D. Miller and W. Dawson, *Worlds that Failed*, part 2, *Disbanded Worlds: A Study of Returns to the Mental Hospital* (Sacramento: California State Department of Mental Hygiene, Mental Health Research Monograph No. 7, 1965), p. 48.
24. It should also be noted that in Eastern Shore counties the ratio of the aged to the rest of the population is two or three times higher than that for the other parts of the state. See Lansdale and Bechill, *op. cit.*, part 1, p. 29.
25. Lansdale and Bechill, *op. cit.*, part 1, p. 23.
26. The high proportion of voluntary admissions among alcoholics is interesting in that they, like the other diagnostic groups, are exposed to physicians in hospitals who could commit them on two-certificate admissions but may be reluctant to do so for reasons that are not entirely clear.
27. In essence, the various approaches of the hospitals to initial ward assignments should be studied further in order to optimize resources and minimize transfers of patients within hospitals.
28. A similar classification was used, for reporting purposes, by the Department of Mental Health, State of Illinois. The classification pinpoints the "schizophrenic," "manic depressive," "all other psychotic," "alcoholism," "diseases of the senium," and "all others." See Division of Planning and Evaluative Services, *Administrators' Data Manual* (Springfield: Department of Mental Health, State of Illinois, 1967). Another group, the retarded, in the few instances where they were found, were included among the other categories when they manifested the appropriate symptoms for those categories.
29. In this category there is often accompanying depression or psychosis, and so there is some overlap with other categories. In this study, when both a psychotic condition and an organic brain condition are pinpointed, the patient is classified as having "organic brain syndrome."
30. When the alcoholism appeared severe enough to seriously impair social functioning,

the patient was considered alcoholic and classified as such, no matter what other conditions were present.

31. *Baltimore Evening Sun* (June 19, 1972), p. C-1.
32. Editorial note, "Characteristics of Aged Alcoholics Studied," *Geriat. Focus* (April 1, 1968), pp. 1-5.
33. See, for example, M. W. Riley and A. Foner, *Aging and Society* (New York: Russell Sage Foundation, 1968).
34. Physicians in state hospitals report a surprisingly low rate of malignancy. A related finding was reported by a team of doctors in Detroit who found schizophrenics resistant to cancer. See *Baltimore Sun* (Feb. 11, 1973), p. C-9.
35. See James E. Birren, "Reactions to Loss and and Process of Aging: Inter-relations of Environmental Changes, Psychological Capacities, and Physiological Status," in Martin A. Berezin and Stanley H. Cath, Eds., *Geriatric Psychiatry* (New York: International University Press, 1965), p. 108; Killian, *loc. cit.*; M. A. Lieberman, "Relationships of Mortality Rates to Entrance to a Home for the Aged," *Geriatrics* 16 (October 1961), pp. 515-519; D. L. Miller and M. A. Lieberman, "The Relationship of Affect State and Adaptive Capacity to Reactions to Stress," *J. Geront.* 20 (October 1965), pp. 492-497.
36. E. Cumming and W. E. Henry, *Growing Old, The Process of Disengagement* (New York: Basic Books, 1961); Lowenthal, *op. cit.*, pp. 220-234.
37. I. Rosow, "Housing and Local Ties of the Aged," in *Middle Age and Aging* (Chicago: University of Chicago Press, 1968), pp. 383-389.
38. H. Padula, *et al.*, *Approaches to the Care of Long-Term Mental Patients* (Washington, D.C.: Joint Information Service, American Psychiatric Association and National Association for Mental Health, 1968), p. 3.
39. Two thirds of the chronic patients can live in the community if sufficient transitional facilities and adequate outpatient care are supplied (Padula, *et al.*, *op. cit.*, p. 88).
40. Because of the limitations of this study, the Baltimore County GES was not visited.
41. A note of caution is in order here. A recent study revealed that increasing the professional services to the elderly may result in a higher rate of institutionalization rather than a lower. The institutionalization may, however, be in nursing homes rather than mental hospitals [M. Blenker, M. Bloom, and M. Nielson, "A Research and Demonstration Project of Protective Services," *Soc. Casework* 52 (Oct. 1971), pp. 483-499.]
42. Goldmeier, *Assessment*, *op. cit.*, pp. 37-55.
43. J. Shapiro, "Single Room Occupancy: Group Work with Urban Rejects in a Slum Hotel," W. Schwartz and S. R. Zaliba, Eds., *The Practice of Group Work* (New York: Columbia University Press, 1971), pp. 25-44.
44. Provident, Inner City, and Catonsville community mental health centers.
45. R. M. Glasscote, *et al.*, *The Community Mental Health Center, An Interim Appraisal* (Washington, D.C.: Joint Information Services, American Psychiatric Association for Mental Health, 1969).
46. To this number should be added a proportion of the 848 beds in the three state chronic-disease hospitals and Baltimore City Hospital. The proportion of persons age 65 and over admitted to these hospitals ranged from 26.4 percent to 62.2 percent in fiscal 1970 (Lansdale and Bechill, *op. cit.*, part 3, p. 34). Clifton T. Perkins State Hospital had an additional two patients.

Aged in Mental Hospitals

47. See Appendix B., Financial Reports of Community Health Facilities, Inc., for more detailed information. The only estimate of the proportion of patients in nursing homes who are age 65 and over is that furnished by the board of inquiry investigating the Gould Convalesarium. The board's estimate, 93.3 percent, is in accord with my estimates of 93 percent, which I arrived at after visiting two nursing homes.
48. For a list of some of the needed services, see Lansdale and Bechill, *op. cit.*, part 4, p. 117.
49. H. A. Simon, *Administrative Behavior* (New York: MacMillan, 1961).
50. R. I. Knee and W. C. Lamson, "Mental Health Services," in *Encyclopedia of Social Work*, 1971 (New York: National Association of Social Workers, 1971), p. 809.
51. In the three community mental health centers I visited, the proportion of persons age 65 and over has never exceeded 2 percent, despite the fact that this group constitutes 7.6 percent of the population.
52. *Baltimore Evening Sun* (Aug. 2, 1972), p. 26.
53. In this study, only 3 of the B alcoholics admitted were over age 70. This forcefully suggests that, if the alcoholic patient is not reached early, he may not live to be a geriatric patient.
54. Social and Rehabilitation Service, Medical Services Administration, *Compilation of Federal Requirements for Skilled Nursing Home Facilities Participating in the Medicaid Program under Title XIX of the Social Security Act* (Washington, D.C.: Department of Health, Education, and Welfare, Publication No. (SRS) 72-24351, 1971), p. 3.
55. *Alternatives to Nursing Home Care: A Proposal*, testimony before the U.S. Senate Special Committee on Aging (Washington, D.C.: Government Printing Office, 1971).
56. E. Markson, A. Kwoh, J. Cumming, and E. Cumming, "Alternatives to Hospitalization for Psychiatrically Ill Geriatric Patients," *Amer. J. Psychiat.* 127 (Feb. 1971), pp. 95-102.
57. See Appendix B, Financial Reports of Community Health Facilities, Inc., for examples pertinent to Maryland.
58. *New York Times* (July 20, 1972), p. 30.
59. B. G. Berkman and H. Rehr, "Social Needs of the Hospitalized Elderly: A Classification," *Soc. Work* 17 (July 1972), pp. 80-88.
60. *Baltimore Evening Sun* (July 7, 1972), p. 25.
61. Berkman and Rehr, *op. cit.*, p. 85.

This report was prepared for the Commission by John Goldmeier.

6:

Levels of Care, Their Cost and Their Effects on Nursing Home Placement: A Study of Keswick

The purpose of this report is to look at the way in which our society places a person in a nursing home or chronic-care hospital and why it is less than satisfactory. This is done by looking at the present levels of care in Maryland, analyzing the chaos that prevails in nursing-home placement, and relating these observations to the actual levels of care, costs, and staffing patterns in one particular institution, the Keswick Home for Incurables in Baltimore.

INTRODUCTION:

- Mrs. Armstrong is 78 years old. She has been living alone on Social Security and Old Age Assistance benefits for 20 years; her only relative, a niece, lives across the city. She often leaves her stove on and falls down with increasing frequency. The owner of her apartment has just sold the building and the new owner wants her to leave. What kind of care does this woman require, how will she obtain it—and what does *she* prefer?
- Mr. Benson, 63, was taken to the hospital with complete occlusion of the left carotid artery—which caused right hemiplegia, further strokes, and a condition interfering with his ability to move. A crane operator, he is married, with three grown children—and his own home. He requires extensive post-hospitalization medical care, and meager family savings make him ineligible for Medicaid. How will he find and pay for the medical care he needs?

These two cases illustrate the problems facing thousands of persons and their families each year in Maryland, as they grapple with the decision to place a person in—or to enter themselves—a long-term care institution, usually a nursing home—and in finding and financing such care. It is difficult to understand the process required to *certify* a person for a *level of care*.

Once the person's need has been established, the process begins of finding a place in an institution offering the kind of care needed. This is all too often difficult and discouraging. There is no central place with a list of available

beds or lists of homes that might provide the particular kind of care and programs a person might need. The process becomes one of calling home after home at random and hoping there will be a bed, and if so, that the home will accept the individual. If the person is on Medicaid and requires much personal care, the home may well choose not to admit him or her because of the amount of expensive staff time required. If the person needs chronic care, the situation is worse—there are almost no beds.

Once a place to go is finally found, there is fear that the care will be inadequate (particularly for those on Medicaid who need maximum skilled care, or for those needing chronic care in a skilled home). Few homes are staffed, and none are adequately paid, for the patient who needs maximum care. With the decision to institutionalize a person difficult to make, the certification for level of care not well understood, the appropriate bed almost impossible to find, and the nursing staff only marginally adequate, it is easy for the patient and the family to become dissatisfied, frustrated and sometimes bitter.

Levels of Care: In order to assess the care needed by a patient entering a long-term-care institution and to help determine which type of facility would be most appropriate, the State Department of Health and Mental Hygiene has a long-term-care classification system. Every person needing such care—who is eligible for state medical assistance, is evaluated and classified by the State Department of Health and Mental Hygiene or the local health department. There are four levels, three of which conform to federal guidelines; the fourth level, chronic care, is unique to Maryland.

Chronic Care: (Evaluations for this level are done by the State Department of Health and Mental Hygiene).

Patient Categories in Chronic Care: Terminal conditions (life expectancy not more than 90 days); intractable pain; difficulty in breathing; recurrent ascites; needs too great to be met in nursing home (terminal states of carcinoma, nephritis, cirrhosis, etc.). Those who require more regular or more frequent attendance of a physician than available in most skilled nursing homes. Examples: Patients with frequent bouts of severe respiratory or cardiac failure. Those in need of continuous skilled nursing service rendered by RN or LPN under the supervision of an RN (This nursing service is not usually available at skilled nursing homes.):

- (1) Comatose patients in need of complete bed care, tracheostomy care, or who have serious decubitus ulcers, etc.
- (2) Patients considered rehabilitatable.

Institutional Services: Facilities provide diagnostic and treatment services under the supervision of physicians, who are members of an organized medical staff; they also provide professionally directed continuous nursing services.

Skilled Care: Evaluations for this and the next two levels of care are done by the local departments of health).

Patient Categories for Skilled Care: Patients who need skilled observation for such problems as heart disease requiring close attention to vital signs or drug toxicity; diabetes which is unstable and requires frequent urinalysis, with possible changes in dietary or drug therapy; respiratory insufficiency requiring oxygen, etc.; mental changes which require potentially dangerous drug therapy or may cause the patient to endanger himself or others.

Patients who need skilled treatment such as inhalation therapy, special skin or decubitus ulcer care, nasogastric, or intravenous feedings, etc. They may also need special service such as physical, occupational, or dietary therapy, or social work counseling.

Institutional Services: This is a medical-care institution whose primary and predominant function is to provide skilled nursing care. Nursing services are under the daily supervision of a registered nurse and at all times a registered nurse or a licensed practical nurse is on duty. Effective arrangements must be maintained whereby ancillary services such as laboratory and X-ray, are readily available, but not necessarily within the facility.

Intermediate Care A: (Evaluation by the local departments of health).

Patient categories for Intermediate Care A: Patients who require a 24-hour plan of care developed by licensed personnel, but only limited supervision, observation, or treatment by such staff; most of their needs can be met by less qualified personnel.

Examples: (1) An aged patient who is mentally confused and may wander off, has problems dressing, or caring for personal needs, and may have other physical problems.

(2) A stroke patient who has benefited as much as possible from hospital and rehabilitation, but continues to need bed care; may be incontinent.

(3) A patient with a troublesome colostomy, needing help with it, and who may also need help in activities of daily living.

Institutional Services: These institutions (Intermediate A) provide limited nursing services and complete personal care services. There is daily supervision by a full-time licensed nurse who may be an RN or LPN, eight hours a day. The nursing plan may be delegated to non-licensed personnel at other times. Services are more than room and board, but less than those of a skilled nursing home.

Intermediate Care B: (Evaluation by the local department of health.)

Patient Categories for Intermediate Care B: These patients require a protective, supervised environment. They have no major medical problems.

They need personal services which normally they could perform themselves, but are unable to because of advanced age, physical or mental limitations. They need help of others in carrying out activities of daily living.

Examples: The elderly patient, who is up and about but subject to nocturnal confusion, and needs help bathing, dressing, etc.

The blind patient who needs help in an institutional environment.

The stroke patient who has recovered except for mild aphasia and a mild residual weakness of the extremities.

Psychiatric patients with residual but benign impairment of social functioning as a result either of illness or prolonged hospitalization, who require some supervision in self-care.

Institutional Services: These are non-medical facilities (Intermediate B) providing personal-care services and continuous general supervision. Supervisors need have only the training of a nursing aide.¹

Patient records from the Baltimore City Health Department further illustrate the kinds of medical and nursing problems needing skilled and intermediate care. Patients recommended for skilled care: Recent surgery in a person whose diabetes is out of control; fractured pelvis in a 95-year-old woman; a severely burned patient whose diabetes is out of control; a deteriorating, blind, partially deaf 90-year-old with atrial fibrillations; bladder diverticuli, acute bladder infection, and developing decubitus ulcers; post-auto accident 29-year-old, requiring tube feedings and bladder irrigations due to spastic quadriplegia.

Patients recommended for intermediate care (all show a stable medical condition, with no need for continuous nursing care): Longstanding diagnosis, patient stable; patient stable and not remarkable; ordinary senile arteriosclerosis; wanders at times but could be kept in an intermediate home if a screendoor were placed on patient's room; a diabetic recuperating from an infection, now stable; chronic brain syndrome in a deteriorating 70-year-old with no special nursing needs; discharged from mental hospital in stable condition.

The above definitions and examples show that the levels of care are designed to discriminate between the degrees of nursing care needed. Thus, chronic care requires more nursing care than intermediate care. The nursing care needed, however, is not the only factor used in determining level of care: Sophistication of care must also be considered. There are two parts to this: First, the institution must be able to provide the specialized care the patient needs. A patient needing physical therapy, for example, could go to a skilled nursing home or a chronic-care hospital, regardless of the hours of nursing care needed, but not to an intermediate-care facility because it does not provide physical therapy.

Second, the facility must be able to provide the sophistication of care

needed. A patient who requires daily visits by a doctor cannot be placed in an intermediate-care facility, even if it can provide the necessary nursing care. The definitions of the levels of care themselves emphasize this point: Chronic care "provides diagnostic and treatment services under the supervision of physicians, who are members of an organized medical staff." In skilled care, "nursing services are under the daily supervision of a registered nurse." Intermediate care offers "daily supervision by a full-time licensed nurse who may be an RN or LPN." Thus, both the quality and sophistication of care are major factors in the level of care for which a patient is certified.

It is important to understand why the state developed the chronic level of care and why most chronic-care beds are in state rather than private institutions. Maryland has long had old age county homes. These homes, financed by the counties, took in any older person needing a place to stay and some supervision. There were no state regulations, and with time they became shelters for the very ill although they could provide only limited services, which were inadequate to the needs of their residents.

The state developed a chronic-hospital system as a result of the Almhouse Commission of 1940, which took over the function of the county homes and provided high-level care under state control. Today, there are three chronic-disease hospitals: Montebello (1958); Western Maryland (1957); and Deer's Head (1950). They have a maximum capacity of 910 beds, but a budgeted capacity of 777.²

The Process of Nursing Home Placement: There are two major steps in placing a person in a nursing home or chronic-care facility. The first is relatively easy, done with efficiency and thoroughness; the second is most often difficult and frustrating.

The first main step is getting certification of level of care. To get this certification, however, the person in question has to enter the nursing home placement system, which means going to a doctor or clinic for a medical examination. If the doctor feels that a nursing home would be an appropriate placement, he fills out the SHD-29 form (nursing home placement form) and sends it to the county or city health department. In Mrs. Armstrong's case (one example in the introduction), the caseworker from the welfare department made a special clinic appointment for her. The clinic doctor, after a thorough examination and lab work, completed the form and sent it to the health department; he was later notified, along with the caseworker, of the department's decision about Mrs. Armstrong's level of care.

For Mr. Johnson, who entered the system when he came to the hospital, an SHD-29 was sent to the health department by the hospital, after being completed by the doctor and social worker. For both Mrs. Armstrong and Mr. Johnson someone had to make the initial decision that nursing-home care might be appropriate. Many times, this decision is made carefully and

with the best interests of the patient in mind, which means with the cooperation and agreement of the patient. However, sometimes the decision is made without considering alternatives. This could be the case for Mrs. Armstrong. Even though medically eligible for intermediate care, a foster home might have been a better solution, and one she might have preferred. Because she was under pressure to move out of her apartment, however, and had no close relatives or friends to press officials for a foster home placement, which are difficult to arrange, going to a nursing home became the easiest and quickest solution.

When the SHD-29 forms are sent to the local health departments, how is level of care actually determined? Dr. Howard Mitchell made a study³ of the Baltimore City Health Department, one of 24 departments in the state evaluating patients for level of care, to answer this question. He studied the department for three weeks (from November 29 to December 17, 1971) to analyze the evaluation process. During the study period, 184 nursing placement forms came to the department, approximately the same number for the same period as the year before; to review these applications, there are six nurses and one supervisor. Mitchell believed, as do many others, that SHD-29 is an excellent form that provides a complete enough picture to determine the level of care needed by a patient. (The problem that causes the most delay in processing is that many times the form is neither correctly nor completely filled out. Delay could be avoided often if the questions "Do you certify that this patient is free from active tuberculosis?" could be reworded and made more obvious.) In the case of the 184 applications during the study period, 26 were returned or rejected (returned mostly because the indication of tuberculosis or mental-health status had been omitted) and 158 were analyzed. In 42 cases, additional calls were made, usually to clarify statements on the form.

Dr. Mitchell found that "in most cases the problem was clear cut; the patient was suffering from several very serious medical conditions and required skilled nursing care around the clock. In those cases where there may have been some doubt as to the needed level of care, the patient's welfare was always uppermost, and the nurses in such situations gave the benefit of their doubt to the patient and assigned skilled nursing care." He also indicated that "the underlying medical problems determine, more than anything else, the level of care that will be required."

To determine whether or not the decisions about level of care were generally accurate, Dr. Mitchell followed the 188 cases from the previous year. He found that "of the 188 cases seen initially, only 4 were known to have been changed from intermediate A to skilled care after one year. Of the 159 cases recommended for skilled care initially, 47 had died and 35 were still receiving skilled care. An additional 14 were transferred or admitted to hospitals because of medical problems. It would seem likely, therefore, that

the original determinations of level of care and placement were probably appropriately made." He found, however, only 48 of the 188 cases had been re-evaluated by the health department during the year; all should have been re-evaluated at least once.

Finally, Dr. Mitchell pointed out something in the level of care determination system that appears to be pandemic to services to the elderly: "Discontinuity of patient care. There are a variety of agencies that are concerned with the provision of care or the determination as to financial or medical need for such care. There are no arrangements for reporting back to referring agencies or individuals, with some exceptions. Patients simply disappear from the system."

The above describes how one health department (Baltimore City) determines level of care. However, health departments can only certify a patient for intermediate or skilled care; the nursing home placement form is sent back to the doctor with the request that he send it to the Bureau of Chronic Diseases, State Department of Health and Mental Hygiene. If the doctor feels that the patient is in need of chronic care, he can send the SHD-29 directly to the state. The state determines the patient's medical eligibility in much the same way that the local health departments do, and then places the patient in a state chronic-disease hospital or on a waiting list. If the patient is put on a waiting list, the attending physician can indicate: "Patient in need of chronic hospital care, but physician requests interim placement in a skilled nursing home." The patient will then be eligible for a skilled nursing home, even though a chronic-care hospital would be preferable.

There are two main steps, as indicated earlier, to placing a person in a nursing home or chronic-care facility. The first, determining the level of care needed, is relatively easy. The second, finding an appropriate bed and actually getting into the nursing home or hospital is a much more difficult task. The health departments only certify level of care and take no responsibility for finding beds. The reason for this, they say, is to not let the knowledge of available or unavailable beds influence in any way the decision about what is most appropriate for the patient. If they had to place the patients they classify, they feel that at times they might compromise the patient's best interests in order to get him into an available bed.

Thus, after the patient is certified, it is the responsibility of those initiating the request to find the appropriate placement for him. Since there is no system for finding available beds (i.e., a central bed-registry) it must be done individually for each patient, requiring duplication of effort by social workers, doctors, family, and friends. Since both nursing homes and chronic hospitals have occupancy rates of close to 95 percent, they can be selective of the patients they admit. *Therefore, rather than the patient having a selection of beds, the facilities have a selection of patients.*

In fact, the state regulations clearly state that even though a patient might be eligible for chronic care, "each hospital retains the right to select patients to be admitted in accordance with its own policies and programs." Under this selection process, the patients who have the most difficulty finding a bed are those needing chronic care with little or no rehabilitative potential) and those on Medicaid needing maximum skilled care. There are two reasons why these patients have great difficulty getting appropriate nursing care: An acute shortage of chronic-hospital beds, and the fact that the care required by many of these patients costs more than the state reimbursement under Medicaid.

The Maryland chronic-hospital system is unique. When it first began, the state was anxious to ensure that everyone eligible would receive high-quality care, and it provided this care in the three state hospitals and the D building of Baltimore City Hospitals. Patients with rehabilitative potential and those with none were admitted because there were enough beds, although patients capable of rehabilitation were preferred. Bed shortages began in 1965 and there have been many reasons, two of which are illustrated here: D building, anticipating more funds from Medicare, decided to renovate the building in order to conform with federal guidelines. Half the beds were closed and the staff cut. Unfortunately, however, when renovation was completed, the hospital was not allowed to rehire the additional staff—and the 350 lost beds were never regained. Since then the number of budgeted beds has fallen to 190. Another example is Montebello State Hospital, where the state decided to air condition the building in 1969. Beds were discontinued, therefore, and the staff cut. The work took about 18 months. The State Department of Personnel then said that since the positions had remained vacant more than six months, they had been abolished and could not be refilled.

Hand-in-hand with the cutbacks, there has been an increase in the number of persons needing this type of care. As medicine advances, more lives are saved, some of whom need chronic hospital care. Medicaid and Medicare, at the same time, are becoming increasingly restrictive about care in acute hospitals. As a result, patients leave acute hospitals faster, many of them needing chronic care.

Even though there is a shortage of chronic-care beds, the state has not encouraged their development outside the state system. Good Samaritan, a non-profit, chronic disease hospital, opened November 19, 1968. Because of the fine quality of its facilities, patient costs were \$60 a day, between \$10 and \$15 a day higher than the state was paying at the state chronic hospitals. For the first several months, the state refused to pay anything for patient care, even though many were eligible for Medicaid. Finally, after much negotiation, the state agreed to pay part of the daily cost of the Medicaid patients. Good Samaritan was still unable to meet costs, however, and has had to move progressively away from rehabilitation care toward acute care.

There are only two other non-profit facilities in the state licensed for chronic-care patients: Keswick, with 11 such patients and Levindale, with 56. Keswick is reimbursed at \$30 a day for its chronic hospital care patients.

Because of the shortage, chronic hospitals can be highly selective about who they admit and they take only those patients with potential for rehabilitation. This leaves out most of the very sick, elderly patients needing chronic care. As one person admitted, some of these patients go to skilled nursing homes where the care is inadequate to their needs—and die quickly.

The second reason some patients have difficulty getting appropriate nursing care is that it costs more than the state reimburses under Medicaid. The state reimburses skilled nursing care in the nursing homes at cost plus 10 percent, up to \$18 a day. However, some skilled patients cost more than others, particularly those who need round-the-clock nursing care, but not the sophisticated care that would require, as well as make them eligible for a chronic hospital. Since nursing homes are able to exercise a high degree of patient selection, they prefer patients requiring the least amount of nursing care, which keeps costs down. In defense of nursing homes, it can be said that most do take some maximum-care patients, but limit the number to insure that they either break even (if a non-profit home) or make the profit demanded by their board of directors.

As this discussion indicates, much of the problem in finding appropriate nursing-home placement relates back to variations in costs and staff requirements among patients with similar classifications. Thus, the patients within a particular classification who would require a substantial amount of nursing time, and thereby increase personnel costs, are the last to be accepted by a home. This statement assumes then that: (1) Within each level of care there are variations in required nursing care; and (2) that these variations are reflected in the actual cost of patient care. These assumptions were verified in a study of a Baltimore City nursing home.

Keswick Study: Levels of Care, Costs, Staffing: To discover real patient costs, real cost variations within levels of care, and real staffing requirements, Keswick, a large nursing home and convalescent center in Baltimore, asked United Research Company of Woodcliff Lake, N.J., a consulting firm specializing in hospital costs, to do a complete study of patient care and staffing requirements:

Keswick Home for Incurables of Baltimore City is non-profit and non-sectarian. Chartered by Maryland in 1883, it has operated on three sites and is presently at 700 West 40th St. It is owned in fee and unencumbered by debt. "It is the purpose of Keswick to create and maintain for its patients a totally therapeutic environment in which all influences on the patient are supportive. Toward the accomplishment of this objective, an organized medical staff, headed by a full-time director, and assisted by four part-time salaried, attending physicians has been provided, together with attending

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specialists and consultants in all relevant specialties and sub-specialties." In addition to physician services, the following clinical services are furnished under the overall direction and coordination of the medical director and his staff: Pharmacy, physical therapy, occupational therapy, diagnostic radiology, clinical laboratory, dentistry, podiatry, minor surgery, and speech and hearing service. To help develop a positive environment for patients additional services are provided: Recreational therapy, social services, religious services, barber, beauty shop, volunteer services, and the patient council of Keswick. Keswick is supported by patient fees, Medicaid reimbursement, United Fund, endowment funds, and contributions.

Keswick is licensed for 47 hospital (chronic) beds, 111 skilled nursing beds, and 47 intermediate A beds; a total of 205 beds.

Patients by Sex:

45 male = 21%	164 female = 70%	Total: 209
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Patients by Age:

37	(18%)	under age 65	
22	(11%)	age 65-70	
58	(28%)	age 71-80	
76	(36%)	age 81-90	
17	(8%)	over age 91	Average age = 77 years

Levels of Care; Method of Payment

60 private patients = 29% (not classified by level of care)

10 Chronic	} = 71%
75 skilled	
60 intermediate	

Residence of Patients:

Baltimore City	168	80%	
Baltimore County	29	14%	
Anne Arundel County	6	3%	
Carroll County	1	.5%	
Howard County	5	2%	Total: 209

Origin of Patients:

<i>Nov.-Dec. 1972</i>		<i>1969</i>	
Nursing Home	67 = 32%	Nursing Home	32 = 12%
Own home	113 = 54%	Own home	218 = 83%
Hospital	29 = 14%	Hospital	10 = 4%

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A note of comparison: The Regional Medical Program for Maryland, Statistics Center, in 1970 chose 45 nursing homes at random to study the origin of the patient population. Their results showed the following: Nursing home 10%, hospital 46%, and own home 38%.

Patient Flow (1969 figures):

Admissions: 56. Deaths: 56; Discharges: 4;
Transfers to General Hospitals: 14.

Keswick: Levels of Care and Functional Disability: United Research attempted to formulate optimum staffing patterns needed for each level of care. In the process, it became clear that within each level there is a tremendous variation of nursing need and that averaging the nursing care needed for each level hides this variation. Therefore, the consultants developed a system based on the functioning ability of the patient in order to clarify staffing patterns. The following is the *Patient Evaluation Guide* developed as a guide for assessing nursing needs of a patient:

A. Self Care

1. Complete bathroom privileges
2. Takes own bath
3. Walks freely without assistance
4. Feeds self
5. Dresses self

B. Minimum Care

1. Bathroom privileges with help
2. Walks with help
3. Feeds self
4. Soaks—no more than 3 times a day
5. Major dressing change—not more than once a day
6. Requires some help in dressing
7. Requires bedding change once in 8 hours

C. Intermediate Care

1. Must be assisted out of bed
2. Requires help in taking bath
3. Requires help in feeding
4. Requires help in turning
5. Requires extensive help in dressing
6. Requires bedding change once in 4 hours

D. Maximum Care

1. Must be lifted out of bed
2. Must be bathed
3. Must be fed
4. Requires more than one person to assist in moving
5. Treatments and/or dressing change every 3 hours or more
6. Must be dressed
7. Requires bedding change once in 3 hours

It would be assumed that if levels of care were directly related to amount of nursing care needed, essentially all intermediate A patients would fall into the A category, skilled patients would primarily be in the B and possibly C categories, and chronic patients would fall into D classification. Table 1 shows this is not true. Patients in each level of care fall into all four categories, which shows the large variation in functional ability (and related nursing care required) within each level. However, the greatest percentage of patients in each level fell into the D category.

TABLE 1. A comparison of levels of care and categories of functioning ability.

Level of care	Functioning level								Total (No.)
	A		B		C		D		
	(No.)	(%)	(No.)	(%)	(No.)	(%)	(No.)	(%)	
Intermediate	13	25	9	17	11	21	20	38	53
Skilled	9	17	7	14	10	19	26	50	52
Chronic	0	0	2	22	1	11	6	67	9
Private	12	18	10	17	13	20	30	45	66

After the patients were reclassified according to functional ability, a study of the care given to each of the 202 patients was made to determine what percentage of staff time (all levels of nursing personnel) was given to patients in a particular classification: A patients required 3.7 percent of nursing time; B patients required 7 percent of nursing time; C patients required 15.7 percent of nursing personnel time; and D patients required 73.5 percent of nursing personnel time.

It becomes obvious from these figures that patients in the A category required far less care than those in D. Yet of the patients actually needing skilled care, 17 percent were in the A category and 50 percent were in D. If a nursing home would run a simple functional ability test on the applicants and choose primarily those falling into the A and B categories, it could save personnel time and keep costs well under state reimbursement rates and make larger profits. As mentioned earlier, nursing homes are to some degree already doing this. The Keswick study only reinforces what many homes have already learned, that choosing the most healthy patients keeps costs down—therefore, the person needing maximum care has the most difficult time finding a bed because of the extra nursing time he or she requires.

Keswick: Cost of Patient Care. The cost of patient care at Keswick is greater than the state reimbursement and is probably greater than at almost any other nursing home in the state. The institution is working toward optimal care ("care second to none") for each patient. A full-time medical director with four part-time salaried attending physicians and a social work

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department are just two services provided that can be found in few other homes in the state.

To find the average cost of patient care, United Research Company took the total operating costs for the months in question (Nov. and Dec. 1972) and computed them into per-day/patient-day costs (Table 2). The figure for salaries is an average for that level of care and thus hides the extreme differences in the actual need for nursing care within a given level.

TABLE 2. Cost of care per patient day, by level of care.

Expenses	Chronic care (dollars)	Skilled care (dollars)	Intermediate care (dollars)
Salaries	35.05	27.86	20.06
Food	1.31	1.31	1.31
Insurance	.30	.30	.30
Heat, light, water, fuel	.60	.60	.60
Supplies, equipment	1.45	1.45	1.45
Total cost per patient day	38.71	31.52	23.72

Payroll costs average \$24.85 a patient day, of which \$14.58 (or 59 percent) is for nursing personnel. Nursing personnel represent 51 percent of the overall costs at Keswick. In a study done of the cost of nursing homes in Ohio,⁴ nursing care represented 43 percent of the total costs in non-proprietary homes and 41 percent in proprietary homes.

As part of their study, United Research documented all extra individual patient costs such as doctor visits, clinic visits, lab charges, physical therapy and pharmacy, to determine the average extra costs patients incurred per day. They are: Chronic, \$2.03; skilled, \$.22; intermediate A, \$1.50. These figures represent costs over and above those incurred in normal operations of the institution, and in many cases are not reimbursed by Medicaid.

In addition to determining the average cost per patient day by level of care as shown in Table 2, the per patient day cost was computed by level of functional ability (Table 3). The salary differences are based on percentage of staff time needed to care for patients in each functional category.

The figures in Table 3 show the wide discrepancy in costs of patient care, depending on the self-care abilities of the patient. For two skilled patients, both being paid for by the state at \$18.00 a day, there can be a difference of \$39.41 in the cost of care. The same holds true for the intermediate patient (reimbursed at \$17.00 a day). Again, there are obviously tremendous cost savings in selecting persons within a level of care who are functionally self-care or minimum care. Some of Keswick's high per-patient costs come

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TABLE 3. Cost of care per patient day by level of functioning ability.

Expenses	Self care (A) (dollars)	Minimum care (B) (dollars)	Intermediate care (C) (dollars)	Maximum care (D) (dollars)
Salaries	5.45	12.08	22.47	44.86
Food	1.31	1.31	1.31	1.31
Insurance	.30	.30	.30	.30
Heat, light, water, fuel	.60	.60	.60	.60
Supplies, equipment	1.45	1.45	1.45	1.45
Total	9.11	15.74	26.13	48.52

from the fact that 46 percent of its patients are D (maximum care) patients, whose care costs \$48.52 a day. The institution could lower costs considerably if it made efforts to select patients other than those in the D category.

Keswick: Staffing Patterns. The state has set minimum staff requirements for both skilled and intermediate care homes:

Skilled Care: "Sufficient trained and/or experienced personnel shall be employed to provide a minimum of two hours of bedside care per patient day. There shall be at least one RN or LPN on duty at all times and in charge of the nursing activities during each tour of duty. The ratio of nursing service personnel on duty to patients shall not be less than 1 to 25, or a fraction thereof, at any time."

Intermediate A Care: "A sufficient number of trained and/or experienced personnel shall be employed to provide a minimum of two hours of bedside care per resident day. As a precaution against a need in case of emergency, a ratio of personnel on duty to residents shall not be less than 1 to 25, or fraction thereof, at any time. Dietary and housekeeping personnel are to be excluded from this count."

The Health Facilities Association of Maryland, a lobbyist trade association, prepared a *Pro-Forma Operating Statement for a 100-Bed Skilled Nursing Home* to show costs and actual staffing patterns that would meet the state requirement. In the analysis of this report by Edna M. Stilwell it was noted: "While the staffing indicated for nursing in the *pro-forma* meets the absolute minimum legal requirements, it cannot support the nursing services required for patients that meet the classification standards for skilled care." She also pointed out that staffing patterns in the *pro-forma* statement, as well as the minimum state requirements, do not provide the quantity or sophistication of care needed by many patients in skilled or intermediate homes.

She concluded that staffing patterns in the *pro-forma* statement allowed 115.6 minutes per patient per day (slightly less than the 2-hour required minimum) but the patients she described needed an average of 154

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minutes per day—a difference of 38.4 minutes per day. She also pointed out that the 115.6 minutes per patient per day could only occur if “all personnel listed would be present. It has been assumed that there would be 7 hours productive work from every 8-hour shift, which may be as much as 2 hours high.” Data on staffing patterns at Keswick supports Stilwell’s conclusions.

Nursing homes in the state that adhere to the staffing patterns proposed in the *pro-forma* statement *make no allowances for absences of any kind*. Thus, any absence will drop the nursing care below the 2-hour minimum required by the state. As the study of average daily nursing hours per patient at Keswick shows, the assumption that there will be little or no absenteeism is wrong (Table 4).

TABLE 4. Average percentage of nursing time paid for over and above that actually spent on the floor.

Level of Care	Nursing time not on floor (%)		Aide
	Registered nurse	Licensed practical nurse	
Intermediate	25	60	29
Skilled	36	30	30
Chronic	62	39	27

Even though there are great variations in extra time paid for among the levels of nursing care, the overall average of extra time paid for is 31 percent. Translation of this figure in order to meet the state staffing requirements means that a nursing home would have to hire enough nursing personnel to give 2.62 hours per patient, per day, of nursing care to get the actual 2 hours per day on floor coverage. Table 4 also shows that more time is lost by RNs and LPNs than by aides, and so to staff a home to meet state requirements, this would have to be taken into consideration.

Stilwell, in her report, raised the issue that the state’s minimum requirements do not provide the care actually needed by most patients in intermediate and skilled homes. Keswick has developed a nursing staffing pattern that it feels gives the sophistication of care the patients actually require, *a pattern well above state minimum requirements*.

Table 5 illustrates three points. First, it shows the actual time paid for as opposed to the actual time spent on the floor by the nursing staff. Second, it shows the actual amount of care given the patients in a particular level of care. Because they are averaged for the particular level of care, the wide difference in required hours of care are not seen. *The most important fact is that the amount of nursing care given at Keswick is substantially above the state’s minimum requirements*. Both the adminis-

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TABLE 5. Paid for and on-floor nursing hours (average daily hours per patient), by level of care.

Level of Care	Nursing time (hours)							
	RN		LPN		Aide		Total	
	Paid for	On-floor	Paid for	On-floor	Paid for	On-floor	Paid for	On-floor
Intermediate	.12	.09	.66	.41	2.53	1.96	3.31	2.46
Skilled	.38	.28	.48	.37	3.31	2.54	4.17	3.19
Chronic	.60	.37	.68	.49	3.33	2.64	4.61	3.50
Total							4.03	3.05

trator and director of nursing feel that the higher number of staffing hours is indispensable to excellent nursing care. *They feel the state's minimum requirements cannot possibly provide adequate, much less quality, care.* (United Research's study did not recommend lowering Keswick's staffing pattern.) The director of nursing never allows the patient/staff relation to drop below 8-to-1—a dramatic contrast to the state's minimum requirement of 25 patients to one staff person.

Third, Table 5 shows that not only do the different levels of care require varying amounts of nursing care, but that as one moves from intermediate to skilled to chronic more sophisticated care is required. This bears out one criterion for determining a level of care needed by a patient: Sophistication of care. Table 6 changes the data in Table 5 to percentages to show more clearly how the sophistication of care increases with each level.

TABLE 6. Percent of care given by RN, LPN, and aide for each level of care (on-floor care only).

Level of Care	On-floor care (%)		
	RN	LPN	Aide
Intermediate	4	16	80
Skilled	9	11	80
Chronic	10	13	77

Table 6 shows not only the changing amount of care given by each staff member, depending on the level of care, but points out that no matter what the level of care, the aide is by far the person most likely to be giving the bedside care.

Conclusions: Placing a patient in a nursing home or chronic hospital is a difficult process. The patient or the family has to initiate the process, find a doctor or medical facility to complete the necessary forms, and then wait for certification of level of care. The local health departments do an

excellent job making level-of-care evaluations, but they can evaluate only for skilled and intermediate, and not for chronic care, which fragments the system. A classic example of this occurred with a patient at the Johns Hopkins Hospital. In the process of determining level of care, two SHD-29s were sent, one to the City Health Department, and one to the State Department of Health and Mental Hygiene. The City Health Department replied that it could not evaluate the patient because he needed chronic care; the State Health Department said they could not evaluate the patient because he needed skilled care.

Finding a place for the patient, once the level of care has been certified, is even more difficult. This has to be done on an individual basis, resulting in wasteful duplication. Because chronic hospitals and nursing homes run at near capacity, they have some choice in the patients they take. The type of patients that are "least chosen" are those on Medicaid who need chronic care and have little or no rehabilitation potential, or those who need maximum skilled care. One reason the chronically ill have placement difficulties is the acute shortage of chronic-care beds. The beds that are available go to the younger person with rehabilitation potential. Chronic patients then end up in skilled nursing homes (the attending physician can authorize this), where they receive inadequate care for their needs and often quickly die.

Patients classified as skilled or intermediate show great variation in the amount of nursing care they actually need, depending on the extent to which they can care for themselves. At Keswick the difference in cost between two skilled patients can be as much as \$39.41 per day. Since all skilled patients are paid for by the state at a maximum of \$18, it is easy to see why nursing homes, given a choice, prefer those who require less care.

Some nursing-home patients, particularly those needing intermediate and maximum care, cannot get the quantity of nursing care they need. The state minimum requirement for nursing staffs simply does not provide enough coverage. Keswick, in order to provide care for skilled patients (of whom 46 percent are maximum-care patients) pays for 4.17 nursing hours per patient day and receives 3.19 on-floor nursing hours per patient day. This is well above the 2 hours of nursing hours per patient day required by the state.

It becomes clear that Maryland's levels of care need to be reevaluated to reflect actual patient needs. At the same time, reimbursement rates need to be adjusted in the same manner—however, to ensure effective care, the minimum required staffing patterns also need to be sharply increased.

REFERENCES

1. 43G02, *Regulations Governing Nursing Homes, Extended Care/Nursing Homes, Long-term Care, Personal Care Homes*; 43G06, *Regulations Governing Intermediate Care Facilities, Long-term Care (Type A)*; 43G07, *Regulations Governing Intermediate Care Facilities, Long-term Care (Type B)*, (Baltimore: State Department of Health and Mental Hygiene, effective as of July 1, 1969).
2. R. T. Lansdale and X. X. Bechill, Eds., *Maryland's Older Citizens* (Baltimore: Department of Employment and Social Services and Maryland Commission on Aging, 1971, part 3).
3. H. Mitchell, "A Preliminary Examination of the Process for Determining Levels of Care and Placement in Skilled Nursing Homes in Baltimore City Health Department" (unpublished report, 1971).
4. GEOMET, "An Evaluation of the Operating Costs and the Cost Impacts of Regulations on Nursing Homes in Ohio" (Cleveland, Ohio: Nursing Home Committee of the Federation for Community Planning, 1972).

This report was prepared by the Commission staff.

7:

Analysis of Pro-Forma Operating Statement for a 100-Bed Skilled Nursing Home Operating in Maryland (FY Ending June 30, 1973)

At the request of the Governor's Commission on Nursing Homes, the *pro-forma* submitted by Health Facilities Association of Maryland in support of a request for an increase in the reimbursement for nursing home care was carefully reviewed with particular attention to the nursing service.

In Appendix A, detailed comments concerning the various items of the *pro-forma* are reported.

GENERAL FINDINGS

1. While the staffing indicated for nursing in the *pro-forma* meets the absolute minimum legal requirements for any home, as will be developed further, it cannot support the nursing services required for patients that meet the classification standards for skilled care. In view of present survey and enforcement procedures, many homes are being credited for skilled nursing care whose mix of patients do not meet the criteria, thus the staffing indicated does, in fact, exist in such homes.
2. As indicated in Appendix A, the overall gross costs listed in the *pro-forma* include enough questionable amounts in areas other than direct patient care that the total cost claimed, if applied somewhat differently, i.e., more and better quality nursing personnel, could support skilled nursing care.
3. Another interesting observation is that the staff indicated, since it is almost the legal minimum, is actually present in nursing homes reimbursed at \$17.00 per patient day, and they are not going out of business. If the rates are to be raised, it would appear desirable to raise them for the purpose of increasing the quality patient care to more nearly the standards that are desired though not now enforced. This could best be done in areas susceptible to audit in terms of numbers and types of qualified personnel and their application to patient care. Since few homes in Maryland are currently providing skilled care it would seem logical that few homes could support the need for increased rates.
4. Nothing herein should be construed as opposing the proposal that rates be increased for reimbursement of skilled nursing care, since this type of care is sorely needed and the present rates of reimbursement cannot pay for adequate care for this type of patient. On the other hand, it would be a disservice to the taxpayers and to the patients needing this care to raise rates as is proposed in this *pro-forma* without improvement in quality of care.

5. Studies in several other states have shown that a large number of patients in skilled care homes are there merely because they need some help in daily living problems and could be in other types of facilities; while on the other hand, studies have indicated that there are older patients in hospitals, not suffering from acute conditions, who require up to five hours of care per day which could be furnished by skilled care homes. Thus there seems to be a strong need to upgrade care in these homes and provide alternatives for the patients that do not need this type of care.

NURSING STAFFING ANALYSIS

1. The following description indicates the amount of time available for nursing care that might be expected from the numbers and types of staff proposed in the *pro-forma* for the 7-to-3 shift.

Position	Responsibilities and functions	Time available for direct nursing services
Director of nursing	Total responsibility and authority for the practice of nursing in the facility	Negligible
(1 RN 5 days per week)	Coordinates with other departments such as dietary housekeeping, etc. Plans for staffing in nursing department, interviews new employees, assists in orientation, staff development and evaluation of performance. Develops and executes budget for nursing. Works with other professionals in developing patient care policies. Evaluates and screens new patients for suitability of staff and facilities to meet needs. Required reports to outside agencies. Liaison with other agencies for continuity of patient care.	
Supervisor (1 RN 7 days per week)	Supervises 2 LPNs and 9 Aides Developing an individualized nursing care plan including assessment of needs, formulating nursing priorities and coordination of inputs of other personnel to updating the plan. Performs direct care where RN expertise is required. Assists in in-service education of staff. Assists physician with certain procedures. Takes and gives reports to assure continuity of patient care.	3.6 min.

	Assumes duties of director during absence of director (director is a 5 day position on the <i>pro-forma</i>).	
	Monitors therapeutic diets when dietician (part-time) is absent.	
Medication (2 LPNs 7 days per week)	Prepares, administers and charts all medications for 95 patients. (Older people require more medication than average patients and more time to administer it.)	9 min.
	Orders medications.	
	Compares doctor's orders, nursing care plan and medicine cards to assure correct medications are given.	Each has 47-48 patients
	Keeps familiar with effects and limitations in administration of each drug. Reports any unusual or undesirable reactions.	
	Assists in nursing care process where appropriate.	
	Assists in transcribing and implementing physicians orders.	
	Assists with treatments.	
Nursing Aides	All nursing care procedures except those requiring the skills of licensed personnel. For example: Personal care, assistance with eating, unsterile treatments, enemas, hot water bottles, assist in getting out of bed, making beds communicating with patient and with supervisors.	39 min.
	Confers with LPN and Supervisor in maintaining the nursing care plan.	
Total 7-3 shift		51.6 min.*

NOTE: The above amounts are considered optimistic since it is assumed that all personnel listed on the *pro-forma* will be present and available for work. We, in essence, have assumed seven hours productive work from every 8 hour shift, which studies indicate may be as much as 2 hours high.

3-11 shift	43.6
11- 7 shift	<u>20.6</u>
Total per day	115.8 min.

2. The following description outlines the possible nursing care requirements for some typical patients that meet the classification of skilled care.

Mr. H. is admitted to a skilled home after exhausting medicare benefits. Primary diagnosis is stroke. He has been receiving physical, occupational and speech therapy. It is anticipated that he will be able to return home in the near future. He needs some assistance with bathing, eating, dressing, and other daily activities due to weakness of one side of his body. He is receiving medication which requires skilled observation for effects and measurement of vital signs such as pulse and blood pressure every four hours. The emphasis for him is rehabilitation and the skilled observation needed to evaluate progress and change nursing plans. He is making satisfactory progress and needs psychological support to continue. The family is cooperating and receiving instruction for his home care in conjunction with community health facilities.

From previous detailed studies, it is concluded that this patient would need approximately *3.16 hours of care*. Of which 25 min. would be RN time, 50 min. would be LPN time and 115 min. for aides, or 13% RN, 26% LPN, and 61% aides.

Mrs. B. is an unstable diabetic who also has a heart condition. She is able to bathe, eat and dress herself, but she has a fatalistic attitude toward her illness and eats candy and other sweets because she feels she is going to die anyway. She occasionally requires oxygen for her heart condition, frequent urine sugar determinations and adjustment of insulin intake and diet, and teaching regarding her health care.

On the same study scale, this patient would only require less than the legal minimum of *2 hours of total care*. However, 20 minutes of this would be an RN, 54 minutes would require an LPN and 30 minutes for aides, or 19% RN, 52% LPN, and 29% aides.

Mr. W. has a fractured hip and is unable to move without help. He needs personal care such as bathing and dressing. He takes frequent medications and requires injections for pain. He is of advanced age and is sometimes forgetful and frequently becomes disoriented as to time, date, etc. He is occasionally incontinent. His hip is just beginning to bear weight and his care plan includes teaching him to walk with crutches.

This patient on the same scale requires about *2.9 hours of care*. Of this, approximately 10 minutes would require an RN, 40 minutes would require an LPN, and 123 minutes of aides' time. The percentages would be: 6% RN, 23% LPN and 71% aides.

To determine actual staffing needs for a home of this type would require a detailed calculation similar to the above. The patients chosen for this sample are not considered abnormal for a skilled care home, since much less need would allow them to go into intermediate type homes; patients in skilled

Pro-Forma Operating Statement

homes with a much greater multiplicity of nursing needs than those selected are not unusual.

Comparison of Skilled Needs and *Pro-forma* in Types and Numbers of Nursing Staff

Patient	RN (min.)	LPN (min.)	Aide (min.)	Total (min.)
Mr. H	25	50	115	190
Mrs. B	20	54	30	104
Mr. W	10	40	123	173
Total	55	144	268	467
Average/patient	18	48	88	154
Average/patient from pro-forma	11.6	18	86	115.6
Deficiency	6.4	30	2	38.4
For 95 patients to meet above requirements (hours/day)	10.5	48	3	59
Numbers of each type	1+	6	0	

Appendix A: Comments

1. *Nursing*: It is interesting to note that nursing hours have not been changed from the previous *pro-forma* and that levels of nursing skills are also held equal. The increase in salary ranges of approximately 11% are generally in keeping with the rates prevailing in the Baltimore area, though somewhat higher than the rates in outlying counties. The estimated fringe benefits of about 20% are in a reasonable range, except in unionized homes. It has been observed, however, that rapid turnover of lower skill level personnel result in few employees actually achieving sufficient tenure to collect many fringe benefits, such as vacation pay and sick leave.

The staff numbers represent almost exactly the legal minimum of personnel to provide nursing care, and as is indicated in Maryland Department of Health guidelines, the numbers would require the most favorable conditions in order to approach the care required by the definitions of skilled care in the Department of Health's guidelines for classification of patients. Thus, it is concluded that even with the present level of reimbursement of \$17.00 per patient day, the amount of staff in the *pro-forma* is now being funded. Thus, the proposed increase of costs in all categories from the \$17.00 of over 20% must be in areas other than

nursing—which is the principal area needing improvement in our nursing homes if we are to improve the quality of patient care.

2. *Occupational Therapy*: With one recreational director, each patient will receive about 5 minutes of his or her time per day, so nursing staff will obviously have to supplement this service. In non-profit homes, volunteers can supplement this service, but in profit making homes, volunteer services are rather rare. The salary range listed is reasonable. It is noted that the salary was not changed from the previous *pro-forma*, contrary to the pattern in other areas of the listings.

3. *Dietary*: The staffing numbers are held constant although titles are changed. The employment of a dietitian for approximately 4 hours a week allows basically for planning special diets but not for day-to-day supervision of therapeutic diets which would fall to the nursing staff. The numbers of diet aides listed would seem to be a minimum to care for dishwashing, setting up trays, serving in the dining room, and clearing the kitchen, leaving the task of delivery of trays to bedridden patients for the nursing aides, since housekeeping personnel, for sanitary reasons, cannot assist with food service. In this category of personnel, the raise of salary is in the 11% range and, in general, the scales appear reasonable.

4. *Housekeeping*: Personnel in this category are again held constant in numbers and level; they are given increase in salary of 9.8% over the former listing. It is considered that this personnel category is the largest of any considered. On a basis of percentage of total payroll, several typical budgets carry this function at about 8% while in this *pro-forma* it is over 12%. This is in addition to substantial budgetary amounts for repairs and maintenance from outside sources, as listed under non-salary expenses. (It is of interest to note that the maintenance man is being carried at \$8,500 per year, which is in the range of professional personnel.)

5. *Laundry*: The salary in this area is up 11% for the same staffing as in the previous listing. The costs listed for laundry seem to be reasonable and probably considerably less than it would cost to use outside contractors.

6. *Administration*: In administration, the staffing is held constant and the salary is raised about 5%, which seems modest. Staffing seems adequate, but there seems to be some duplication in the full time bookkeeper and the contract with an outside firm to furnish computed calculated reports. It would also seem that the annual salary of the administrator, for a relatively small 100 bed home, in the \$15-16,000 range is perhaps at the upper limit of the market.

Another aspect of the *pro-forma* which applies to all positions is perhaps best illustrated in the case of the administrator. In the calculation of payroll costs, including fringe benefits, the assumption is made that the salary of the

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employee during vacation is paid as is the salary of a replacement. In actual practice, seldom is it possible to obtain replacements for key people during sick leave or vacations, thus relatively large cost savings are obtained by having the staff double up to cover for vacations, etc. For example, in the administrator's case, should he take 2 weeks vacation, 6 holidays and 3 sick days without replacement, a savings of nearly 1,400 dollars from the listed payroll costs would result. When this practice is applied to the other positions, including those in nursing, a substantial savings from the listed payroll cost is realized. This item could account for as much as \$35,000 in payroll costs during a year.

Non-Salary Expenses

1. *Nursing Supplies:* Nursing supplies are carried at 11¢ per patient day which is considered reasonable.
2. *Food:* Food is carried at \$55,970 per annum, which for 95 patients averages about \$1.60 per patient day. It is suggested that this amount be compared with other nursing homes and state financed facilities. In addition, the costs of 11¢ per patient day for kitchen supplies is questioned unless all disposable dinner wear is used, in which case the earlier expenses for personnel for dishwashing might be questioned.
3. *Plant Operations and Maintenance:* The sizeable amount under this category like other items in the *pro-forma* is based on the unaudited reports of five homes and the inflationary rate of one home. Since these items can vary widely depending upon the age, condition and location of the homes, intelligent comment is difficult to make. However, reported per bed costs for the construction and outfitting of a nursing home vary from \$3,500 per bed to \$14,000 per bed, depending on the estimator. It is recommended that the Commission examine the assessed value of plant and equipment of a reasonable sample of homes and make its own estimate for this cost. Another interesting aspect of this category is the fact that the sample of five homes varied from 83 to 120 beds. Since the trend to larger homes is fairly recent, there remain a considerable number of older smaller homes in the 50 bed range which could possibly have lower expenses. Since this category accounts for about \$3.50 per patient day it is suggested that it receive special attention.
4. *Administration:* The administrative expenses of \$43,000 per annum seem to be at or near the upper limit of reasonable cost and might be considered typical of a new facility which is advertising for patients and for staff, but not for an older facility. The \$14,000 figure for professional fees should, as stated previously, be considered in connection with time bookkeeper.

COSTS NOT LISTED

The following costs are apparently not included in the *pro-forma*: Occupational therapy supplies, staff development, cost of consultants fees for medical director and losses from bad debts. While each does not add large costs, their cumulative effect could be as much as 40¢ to 50¢ per patient day.

INCOME NOT LISTED

While the *pro-forma* does not address itself to income *per se*, it infers that the total of the cost items listed should be reimbursed without considering other income. In actual practice, however, discounts, commissions, and fees for handling outside services and accounts may in fact create significant income. Some examples are barber services, beauty shop, physical therapy services, pharmacy, equipment sales and rental.

8:

Proposal on Centralized Registry of Beds in Long-Term Care Facilities

Supporting Information:

At the present time patients in acute hospitals or in community residences who require nursing-home care are generally placed in such facilities with maximum confusion and minimum efficiency. One of the great delays associated with placement involves the finding of a nursing home suited to the patient's needs and capacities. It is not unusual for the placing person in an acute hospital to spend many hours trying to locate an appropriate nursing home, particularly when the patient needs extensive nursing care, or has been certified for an intermediate level of care for which beds are extremely limited. When the patient is being placed from his own residence into a nursing home, we do not always know the frustrations which families endure in the process, but if their experiences (with their presumably limited knowledge of the systems involved) are similar to those encountered by persons who perform this function regularly, they must indeed feel the difficulties are almost insurmountable.

It is currently necessary for the placing person to call any or all extended-care facilities in the category for which the patient is certified until a bed can be found which meets the patient's needs and is in a setting which provides suitable staffing and supportive services. Since this is usually done on a 1:1 basis, the time involved and duplication of effort in searching for an appropriate placement by themselves argue for a more efficient system. During this time, in an acute hospital, three problems ensue which can create dysfunction for the hospital if the patient cannot be placed at the time he is medically eligible for hospital discharge: 1) the patient's stay in the hospital can be unreasonably extended; causing 2) an unnecessarily expensive use of hospital resources directly relating to the cost of medical care and health-insurance premiums; and 3) the delay of admission to acute care for some patients in emergency rooms and those requiring in-patient diagnostic or therapeutic attention.

Not only would a more efficient system for locating nursing-home beds profit hospitals and their fiscal resources at both ends of the vendor/carrier

system, but patients, their families, and nursing homes, would also benefit. This proposal submits a framework for "matching" patients and facilities, which would result in overall better utilization of available resources. The present system for nursing-home placement often results in haphazard patient planning, especially when the hospital's need for an acute bed takes precedence over the patient's need for appropriate care, and the patient ends up in a nursing home simply because the home has an available bed, regardless of its suitable provision of services geared to potential restoration or terminal care. Families independently placing patients (in those situations when they have little or no guidance) frequently do not know what services to seek or questions to ask in arranging for appropriate placement, and could be guided by the system presented in this proposal. And long-term care facilities sometimes have vacant beds for unfortunately lengthy periods because their availability is not known to the interested parties. A reporting system such as presented here could offer such homes a legitimate resource for their services.

In summary, therefore, this proposal is geared toward a more appropriate utilization of acute and long-term care facilities, and the efficient expenditure of available fiscal resources.

Statement of the Problem:

Under present circumstances, patients requiring long-term care are certified by local health departments for the appropriate level of nursing care, at which point a frustrating search for a suitable facility begins. This is especially true when the patient needs specialized services because of his medical or functional status. Each acute-care hospital, health agency or facility, or family, must contact all available nursing-care resources until "a bed can be found," which satisfies level-of-care requirements, but regardless of the facility's actual capacity to meet individual patient need.

The Central Bed Registry will be a cooperative venture involving public and private agencies and will depend on their involvement and support for its success.

- I. Administration for Services to the Chronically Ill and Aging, Department of Health and Mental Hygiene. The Central Bed Registry could best operate under the auspices of this Administration for the following reasons: 1) the Registry, being statewide, should be part of an agency that serves the entire state; 2) this Administration is concerned solely with the total needs of the chronically ill and aging, both in institutions and the community; the Registry would become an important part of the Administration's program to assess and develop services for this group of people; and 3) this Administration is responsible for assessing patient needs for chronic care. It also supervises county and city Health

Central Bed Registry

Department programs for assessing patient needs for Skilled or Intermediate care. Tying in with an Administration with this responsibility will increase the effectiveness of the Registry.

- II. Licensing and Enforcement, Department of Health and Mental Hygiene. This Department will work closely with the Central Bed Registry to ensure that the nursing homes continue to inform the Registry of the number of beds available.
- III. Medical and Chirurgical Faculty. The Faculty would act largely in the capacity of educating physicians and other users of the service. It could also aid in cutting down resistance on the part of Nursing Home physicians or Administrators/Owners.
- IV. Maryland Health Facilities Association of Maryland. This Association would be responsible for educating the nursing-home administrators about the program. It would work closely with member homes to ensure that homes continue in the program.

Other agencies involved would be the State Commission on Aging; the Baltimore City Commission on Aging; the Ombudsman Program within the City Commission; and the Statewide Information and Referral Service. These agencies would be a vital force in informing potential users of the Registry and its services.

Personnel and Equipment Necessary:

Implementation of this program could be carried out with a minimum of personnel and equipment. The following are considered basic to the conduct of this program:

1. Four toll-free, statewide telephone lines at a central location;
2. One coordinator/supervisor with the capacity to generate enthusiasm within the functional group, and maintain statistical information for the evaluation of daily efficiency and long-term effectiveness of the program;
3. Four clerical workers to record and provide reported information;
4. Short and long-term evaluation forms for the effectiveness of the central registry, per se, and in the view of placing persons and agencies.

Description of Procedure:

Procedural steps for implementation of this program are basically simple:

1. The director of nursing, head nurse, or an appropriately knowledgeable person in the long-term care facility calls the central registry daily between the hours of 8:30 a.m. and 11:00 a.m. to report vacancies. If

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a representative of any facility fails to report, the central registry contacts the facility to obtain data.

2. Data is recorded on a daily worksheet (attached) in a readily-distinguishable format providing the name of the facility, available number of beds at that agency's licensed levels of care, and the services and/or kinds of nursing care which are actually possible within that setting.
3. Anyone seeking an available space in a long-term care facility calls the central registry between 11:00 a.m. and 4:00 p.m. and is provided with the current listing of vacancies suited to the patient's needs.
4. The seeker then negotiates with the individual facility for actual placement of the patient. The central registry is NOT responsible for the matching of patients to services or placement.
5. On-going evaluation, in a yet-to-be-determined format, will be conducted regularly, both for effectiveness of the registry, per se, and as seen by placement personnel.

Budget

Coordinator	\$ 9,000
Four clerical workers @ \$6,000	24,000
Telephone	800
Supplies	500
	<hr/>
	\$34,300

(Rent supplied free in State Office Building, Baltimore, Maryland)

The registry will be divided into the following areas:

Western Maryland: Allegany, Frederick, Garrett and Washington Counties

Southern Maryland: Calvert, Charles and St. Mary's Counties

Washington Suburban: Montgomery and Prince George's Counties

Eastern Shore Counties: Dorchester, Somerset, Wicomico, and Worcester Counties (lower E.S.); Caroline, Cecil, Kent, Queen Anne's and Talbot Counties (upper E.S.)

Baltimore Metropolitan: Baltimore City and Counties of Anne Arundel, Baltimore, Carroll, Harford and Howard

This proposal was prepared by the Commission staff.

WORKSHEET BY FACILITY

Name of Facility _____

Total Number of Beds _____ Month _____

Levels of Care in Home

Type of Care in Which Home Specializes _____

Date	Number of Beds Available			Description of Beds (sex, Medicaid, private, medical limitations)
	Skilled	Intermediate		
		A	B	
Totals for month				

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WORKSHEET BY DATE

Date: _____

Name of Facility	No. of Beds Available	Description of Beds Available

9:

A Comparison of Nursing Services in Profit and Non-Profit Facilities

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Purpose

This study of nursing homes in Maryland was done at the request of the Governor's Commission on Nursing Homes in an attempt to determine:

1. Differences between proprietary and non-proprietary facilities in relationship to any of the problems studied.
2. Current functions of members of the health team.
3. Patient care and factors influencing this care.
4. Patients in these facilities who could be cared for in their homes if adequate services and persons were available.

Definition of Terms

There are several types of nursing homes. For the purpose of this study they will be defined as follows:

1. *Chronic care.*¹ Cares for: 1) patients with rehabilitation potential and in need of specialized therapy; 2) patients with terminal conditions whose life expectancy is anticipated to be no more than 90 days or those with medical needs too complex to be provided in a skilled nursing home; 3) patients who require more regular and frequent attendance of a physician than is available in a skilled nursing home; and 4) patients in need of continuous skilled nursing services at a level or in an amount ordinarily not available in a skilled nursing home.
2. *Skilled care.*¹ An institution with facilities and staff to render skilled nursing care to persons suffering from disease or other disabilities. Nursing care must be by a registered nurse (RN) or by a licensed practical nurse (LPN) under the supervision of an RN.
3. *Intermediate long term care, Type A.*¹ An institution for residents in need of long term care. The illness is not acute and their need for care has stabilized at a level which requires no more than eight hours a day of care under the supervision of an RN or LPN. The prognosis is such that care will be required for an extended period.
4. *Intermediate personal care, Type B.*¹ An institution which admits two or more persons in need of personal care. These are services which an individual would normally perform for himself but for which he is personally dependent on others because of advanced age, infirmity, or physical or mental limitations. This care includes, but is not limited to, assistance in walking, getting in and out of bed, bathing, dressing, eating, and general supervision and assistance in daily living.

The nursing requirements:

- (a) Supervisor: experienced nurses' aide eight hours a day, five days a week.

- (b) Bed capacity under 50: RN or LPN not required.
- (c) Bed capacity over 50: RN or LPN required 16 hours a week.
- (d) Bed capacity over 100: RN or LPN required 40 hours a week.

All of these facilities are required to have job descriptions, written nursing policies, written nursing care plans and to provide for safety and recreation.

5. *Registered professional nurse (RN)*. A high school graduate and a graduate of an accredited school of nursing, who is licensed by the state.
6. *Licensed practical nurse (LPN)*. A graduate of an accredited school of practical nursing and licensed by the state.
7. *Licensed practical nurse by waiver (LPN by waiver)*. Has not graduated from a school of practical nursing, but has been licensed by the state after passing an examination.
8. *Experienced nurses' aide*.¹ A person with sufficient training and experience to serve in relief for persons with specific qualifications by carrying out their orders and instructions. This capability is determined on the basis of a written personal history in which the experience and training of the person has been recorded, confirmed and approved by the administrator, supervisor and a representative of the Maryland State Health Department.
9. *Principal Physician*.¹ Homes shall arrange for a licensed physician to serve as Principal Physician. The Principal Physician shall respond to calls at times of emergency and be available as needed to advise the administrator on medical questions such as the suitability of residents for admission or retention. He or she shall provide guidance on the execution of resident care policies, and the health program of employees.
10. *Personal Physician*.¹ Each person admitted shall be under the care of a licensed physician of his choice. The name, address and telephone number of the physician or physicians attending each resident shall be recorded for ready reference.
11. *Health Team*. All nursing personnel, the administrator and the physician.
12. *Proprietary*. A profit making facility.
13. *Non proprietary*. A non-profit making facility.

Methodology

1. Selected literature was reviewed.
2. Investigators who had conducted similar studies or who were currently engaged in attempting to devise tools to measure quality of patient

care were contacted for their questionnaires, the results of their studies, the limitations of their studies, and their perceptions of how quality could be measured.

3. Local nurses involved in geriatric nursing and persons doing relevant research were consulted for opinions, knowledge and guidance.
4. Because the quality of patient care eludes exact measurement, other factors were considered and a questionnaire (Appendix) was developed in an attempt to obtain comprehensive data in such areas as:
 - (a) Functions of members of the health team;
 - (b) Patient care and factors influencing it;
 - (c) Patients who could be cared for in their homes if adequate services, resources and persons were available to them.

Experts helped select the questionnaire items in the attempt to obtain a representative sampling of questions in each of the areas to be studied. One limitation, of course, was the potential for eliciting socially desirable responses. The decision was made, however, to include all items, with the hope that the respondents would feel free to answer honestly. Because all facilities in the state were included in the study, the questionnaire was not pretested. The final version of the questionnaire was evaluated by the consulting experts.

5. A list of the licensed facilities in Maryland was obtained from the Division of Licensing and Enforcement of the Maryland Department of Health and Mental Hygiene. All except domiciliaries were included in the study.
6. A questionnaire was sent to the administrator of each facility with a letter explaining the purpose of the study. It was requested that the director of nursing complete it, although the choice of an appropriate person would be based on the organization of the facility.
7. Questionnaires were mailed June 19, 1972, (with return self addressed stamped envelopes) with replies requested by July 10, 1972. Several were returned after that date, including one delayed in the mail, which were included in the study. No follow-up letter was sent.
8. Data were analyzed in terms of the purpose of the study.
9. Conclusions and recommendations were based on the findings of the study.
10. The *N*'s for all tables may vary because not all of the respondents answered all questions. In some tables, the totals will be greater than the *N* because of multiple responses.

FINDINGS

Scope of the Study: The study sample was comprised of the 158 licensed nursing homes in Maryland. The responses were completed by nursing personnel and/or administrators.

Analysis of the Responses: 158 questionnaires were sent to the 113 proprietary and 45 non-profit facilities; 94 (59%) were returned. The breakdown of responses from proprietary and non-profit facilities:

Responding proprietary facilities: 63 (55%)

Responding non-profit facilities: 31 (69%)

Baltimore City and 19 counties are represented in the responses.

Description of the Study Population: Since the responses could be influenced by the background of the respondents, the respondents were asked to identify their position in the facility, their age group and their level of education (Tables 1, 2, 3). Not all directors of nursing and supervisors were RN's; two whose positions were not identified, were not included in Tables 1 and 2.

The majority of respondents in both types of facilities were directors of nursing in the 41-50 age group.

Although most of the respondents were RNs with no further preparation, the levels of formal education of all of the respondents ranged from less than high school to a bachelor of science in nursing degree. There were no master's degrees among the respondents, although two RN's stated that they did have some post-baccalaureate preparation.

Special courses attended by some included nursing home or business administration and a postgraduate nursing course in psychiatry. One RN was currently enrolled in a bachelor of science nursing program.

One indicator of institutional stability is the stability of the administrative personnel. The data from this study indicates that the administrators and directors of nursing had been in their positions more than three years, which indicates a fairly high degree of stability (Tables 4 and 5).

Description of the facilities and their populations: The majority of the facilities were either Skilled or Intermediate Type A and many were licensed to provide both types of care. Table 6 shows that there were very few Chronic Care and Intermediate Type B facilities.

The proprietary facilities had 4,512 licensed beds and the non-proprietary had 2,278 beds, for a total of 6,790 beds.

Respondents were asked for their patient census on the day they answered the questionnaire. Although these figures were not all supplied on the same date, it was felt that because these were primarily long term patients and the turnover rate was low, the total would be reasonably accurate.

The census ranged from three to 351 with a total census of 5,819, reflecting a bed occupancy of 86%. In the proprietary facilities the bed occupancy was 81%, in the non-proprietary it was 94%.

Criteria for the Admission of Patients: Certain diseases or conditions were the main reasons for reluctance to admit patients (Table 7). This could be a justifiable reason, depending upon the type of care the facility was licensed to give. As seen in Table 7, many facilities indicated more than one reason for restricting admissions.

Several respondents explained that their decision to admit noisy or confused patients depended upon the degree of noise or confusion. Others expanded on diseases they did not accept, which included contagious diseases, mental illness and alcoholism.

Additional reasons for reluctance or refusal to admit patients included age and residency requirements: No children,; no male patients accepted; no one accepted but county indigent patients; long term chronic hospital candidates requiring institutionalization for socio-economic rather than medical reasons; and patients who must be fed, who smoke, who require intravenous therapy or blood transfusions, or who require special equipment the facility would be unable to provide. A reason not given by the respondents, but which might influence admissions, could be the religion of the applicant.

The data were analyzed in terms of sex and race. Although the numbers of non-whites look smaller, they must be considered in proportion to the total population in these facilities. Looking at it this way, the number of non-white males in non-proprietary facilities was found to be proportionately greater than in proprietary facilities. The same ratio held true for non-white females. The converse of this was true for white males and white females. This difference was statistically significant at the .001 level of probability (Table 8).

The smaller number of males in relation to females may be due to: 1) The shorter life expectancy of men; and 2) the fact that many women care for their husbands at home. When women are admitted to these facilities, many of them, therefore, could be widows with no one to care for them at home.

Of the nursing home population in the study, 11.9% were non-white. In Maryland, non-whites make up 18% of the general population, but only 13.2% of the population 65 and over, the age group of most of the nursing home population.

When the data were analyzed in terms of the recipients of Medicare, it was found that the distribution between males and females was fairly even in the two types of facilities (Table 9). However, when the data were analyzed in terms of the recipients of Medicaid, it was found that the recipients were mostly women; and most women were in proprietary facilities (Table 10). This finding is consistent with the fact that there are more females than

males in these facilities and the difference was statistically significant at the .01 level of probability.

Among private patients it was found that there were more women than men, and of the women, most were in proprietary facilities. This difference was statistically significant at the .001 level of probability.

Staffing Patterns: Proportionately, there were more full time RNs and LPNs in the non-profit facilities than in the proprietary. Conversely, there were more aides and male attendants in the proprietary facilities than in the non-proprietary. These differences were significant at the .01 level of probability (Table 12).

When the part-time personnel were considered, proportionately there were more RNs and LPNs in the proprietary facilities than in the non-profit. Conversely, the proportion of aides and male attendants, in the non-profit homes was more than in the proprietary. These differences were significant at the .001 level of probability (Table 13).

Analysis of full and part-time personnel combined (Table 14) revealed proportionately more RNs and LPNs in non-proprietary facilities than in proprietary. This was statistically significant at the .02 level of probability.

In every personnel category, the average number of patients per person was less in the non-proprietary facilities than in the proprietary. For example, Table 15 shows that proprietary facilities had an average of 15 patients per RN (full and part-time), whereas non-proprietary facilities had 14 patients per RN.

Patient care assignments were considered separately for the day and evening shifts during the week and for the day and evening shifts on weekends. In all instances the modal categories of both types of facilities were consistent. On the day shift during the week and on weekends 6-10 patients were assigned to each person giving care, while on the evening shift during the week and on weekends each person was assigned 11-15 patients.

While these are the average numbers of patients per person, the high ratios of personnel to patients in the RN, LPN and male attendant categories, in addition to other responsibilities, virtually precludes the possibility of them being involved in much direct patient care. Therefore the aides must be the ones who give most of this type of care.

The requirements for RN and LPN coverage in a 24 hour period vary from 0 to 24 hours depending upon the types of facility. (In intermediate Type B facility it depends upon the number of beds.)

The average number of hours of RN or LPN coverage in all facilities is shown in Table 16.

The problem of absence on weekdays or weekends was denied by the few who responded to this question. It is possible that some defined absence as being only an unexcused absence and did not include legitimate absence due to illness.

For both profit and non-profit homes, over half the homes reported a general nursing staff turnover of 25% or less (55% of proprietary homes and 62% of non-profit homes). Each category of nursing personnel for both proprietary and non-profit homes fell into this general range with the non-profit homes showing slightly lower turnover (Tables 17 and 18).

B. Responsibilities and Functions of the Health Team

Charge Responsibilities: Since many facilities employ no RNs, or employ a minimum number, and since many of them are employed part-time, others must assume charge responsibilities in the nursing office and on the wards (Tables 19 and 20). Since these responsibilities are assumed by different people at different times, the number of responses is greater than the sample size.

In the nursing office, charge responsibilities were assumed primarily by the RN, and to a lesser extent, by the LPN and the administrator. On the wards, the same members of the health team, except the administrators, assumed charge responsibilities, but the number of aides and LPNs by waiver was greater than in the nursing office. Some responses were qualified by statements that the aides were the charge, senior or medicine aides or trained nursing assistants.

Medications: Oral and injectable medications were administered almost exclusively by RNs and LPNs. A few used other specifically trained personnel, especially for oral medications (qualified by some as only at night or in an emergency) (Tables 21 and 22).

Twenty three respondents said they did not perform intravenous procedures in their facilities. In those where they are performed, it was primarily the responsibility of the RN, although LPNs and specifically trained personnel, as well as physicians and laboratory technicians, also performed them.

Regardless of the personnel administering medications, all levels of personnel, including the administrator, assumed responsibility for taking appropriate action in the event of medication side effects. The director of nursing and the RN were primarily involved (Table 23).

Decisions: All nursing personnel and the administrator could make the decision to call the physician when a patient's status changed, although primarily it was a function of the director of nursing and the RN (Table 24). In two facilities where aides were allowed to make this decision, respondents qualified their responses by adding that this person was the charge or senior aide.

Fifteen respondents (16%) felt that there were judgments now being made by physicians that could be made by RNs, LPNs, or administrators. No one elaborated on what judgments they felt administrators could make, but one

LPN stated that she felt she could make judgments on decubitus care and 10 RNs felt judgments that they were capable of making included:

- 1) Patient management and care, such as caring for decubitus ulcers, diet planning, exercise regimens and protective measures;
- 2) Providing emergency measures until the physician arrives and transferring patients to hospitals in emergency situations;
- 3) Writing and signing prescriptions on longstanding drug orders;
- 4) Ordering certain laboratory studies;
- 5) Signing and completing applications for levels of care for medical assistance, and patient evaluation for utilization review.

Very few of the respondents in either type of home felt that the policies and practices of the facility had violated good nursing practice. For the few who did respond affirmatively, it is interesting to note that they had taken action in each instance. The nature of these actions was not stated (Table 25).

Assignment of Patient Care: Because of the low turnover rates of patients in nursing homes, personnel become familiar with the patient care required, and the methods used for assigning this care differs considerably from those methods used in acute care settings. As shown in Table 26, master assignment sheets were the primary method used to communicate assignments, although many facilities used more than one method.

Other methods of assignment which were reported were using the nursing care plan on the Kardex or writing them only when there was a change.

Inservice Education and Patient Care Conferences: Two possible ways of increasing and maintaining interest in the quality of patient care are regularly scheduled inservice programs and patient care conferences. The former usually covers broad areas and ideally might include such topics as the process of aging, the philosophy of rehabilitation and aspects of long term care, which can be used in planning care for individual patients in patient-care conferences.

Although respondents were not asked to identify the content of their inservice programs, 52.3% felt their facilities had an adequate education program, while 47.6% felt it was inadequate (Table 27).

Table 28 shows that personnel in the majority of the proprietary facilities spent an average of 0-2 hours a week conducting patient care conferences, while in the majority of the non-proprietary facilities they spent an average of 2-4 hours a week in this activity.

In addition to inservice education programs and nursing care conferences, personnel, including administrators, utilized other sources for expanding their knowledge in the field of gerontology. Table 29 shows that most of them read books or journals and attended conferences or seminars in order

to keep abreast of current practices—as well as attending administrative courses and national meetings.

Six respondents, three in proprietary facilities and three in non-proprietary facilities, had not updated their knowledge. These responses were in addition to those who were too busy because of job requirements.

Role of the Physician: Many facilities had both private and principal physicians on their staffs. As seen in Table 30, they were fairly evenly divided between both types of nursing homes. In addition, there were 16 medical directors in the proprietary facilities and 11 in the non-profit facilities.

Federal nursing home regulations stipulate that patients must be seen and medications must be renewed every 30 days in skilled facilities and every 90 days in intermediate facilities. By far, the greatest number of both private and principal physicians carried out these functions at least once a month. In a few facilities, patients were seen less than every 60 days and medications were renewed every three months. (See Tables 31, 32, 33).

Almost all respondents felt the frequency of physician visits was adequate although between visits some physicians were available only by telephone—or were sometimes difficult to reach (Table 39).

Meals, Linen Housekeeping: In general, these are not nursing functions, but at times nursing personnel perform them. In the majority of the facilities, none of these functions were performed by nursing personnel. In the institutions reporting that nursing personnel performed these duties they cited reasons such as relief for the regular person (Tables 35, 36, 37).

Discharge of Patients and Continuity of Care: In both proprietary and non-proprietary nursing homes, death was the primary mode of discharge. Very few patients were discharged to their homes, foster homes or to other facilities (Table 38).

Current trends suggest many patients in nursing homes could live in the community in their own homes or with their families. This is especially true when community support services such as visiting nurse associations, Meals on Wheels and day care centers offer help. Community living not only would help to preserve the patient's independence, but also would reduce the expense of care. As shown in Table 39, more than half the nursing personnel believe that less than five percent of the currently institutionalized patients could live adequately at home. This may be because of a lack of awareness of community resources, because of traditional thinking, or it may reflect the true situation.

Since elderly people frequently take a variety of medications, an important factor in considering alternative arrangements is the ability to administer their own medications.

In both types of nursing home facilities, nursing personnel felt patients

could not administer their own medications (Table 40). This probably reflects institutional policy and is not a good indication of whether or not they could function at home. This traditional view may have influenced the respondents' decisions.

More than half of the homes reported that 25% or less of their patients could not be discharged either because there is no family or the family will not take the patient (Table 41). A slightly higher percentage of proprietary homes indicated this than non-profit homes (83% and 60% as opposed to 60% and 55%). Apparently most homes do not see the lack of family or lack of family willingness to care for the patient as important reasons for the patient not being discharged from the nursing home.

For those patients who are discharged to their homes, continuity of care has broader implications than the day to day care and assessment of patients within the nursing home facility. In order that rehabilitation accomplished in the facility not be lost in the transition from facility to home, predischARGE planning is vital. The family may be eager to have the patient return home, but they may not be equipped to meet the problem they will encounter. Nursing personnel have the responsibility to show awareness of potential or real problems and to make advanced preparation by consulting with the appropriate persons. As shown in Table 42, discharge planning most frequently involved the patient's family and physician, the social services department, and the patient. Public health personnel, who have been identified as appropriate persons to give support in the home to patients and their families, were among the least frequently consulted persons.

Other agencies and individuals consulted included the visiting nurse associations, Meals on Wheels, senior citizen groups, hospital home health services, rehabilitation nurses, dieticians, and physical and occupational therapists.

Equally important is the planning and communication with other nursing personnel when a patient is transferred to another facility. This was accomplished by one respondent through the use of the transfer sheet and by talking with the head nurse in the facility to which the patient was going.

C. Patient Care

Kinds of Patient Care: The ambulatory status of patients, the problems of incontinence, the ability to care for and feed themselves, and the number who are mentally confused or have dicubiti and how these problems should be handled are indicators of the kinds of patient care required.

The differences in the ambulatory status of the patient population are shown in Table 43. While some patients were either ambulatory or confined to bed in both types of facilities there was a larger middle group that required some assistance, which included being up in a chair or wheelchair or walking with a walker or cane.

The problems of incontinence are shown in Table 44. Any patient might have fallen into two or more categories, and from the data it was not possible to determine which ones.

Over 80% of the patients in both types of facilities required either complete care or some unknown degree of assistance with personal care (Table 45).

The differences in the abilities of patients to feed themselves are shown in Table 46. In this activity the majority of them were independent.

Mental confusion was not defined except to specify that all patients in this status be included whether or not they had a diagnosis of senility. The perception of who was mentally confused was left to the judgement of the respondents. Over 54% of the proprietary facilities and over 27% of the non-proprietary facilities reported that more than 50% of their patients were mentally confused (Table 47). Factors which may account for the differences between facilities may be due to individual perceptions, selectivity in admitting patients, inaccurate reporting, or true differences.

Several factors must be considered in determining the manner in which confused patients are cared for. These include: The number of patients to be controlled and the degree of control necessary, the available staff, the interest and knowledge of the staff, and the facility's physical layout. Although the majority of the facilities used more than one method for controlling patients, medications and restraints were the major nursing interventions employed (Table 48). Segregation of patients into private rooms was the least used intervention.

Other interventions reported were geriatric chairs, side rails, individualized care according to need, and baby gates to block the doors of patients' rooms.

Patients with decubitus ulcers presented nursing care problems, although not to the same extent as mentally confused patients. Findings indicated that in the majority of both types of facilities 5% or less of the patients had decubiti and many reported that none of their patients had them (Table 49).

In almost all instances, nursing intervention included reporting the decubiti to the physician and then following the physician's orders. Some nursing personnel, without a physician's order, placed patients on air mattresses, instituted medications or changed the patients' position in bed (Table 50).

Nursing Interventions for Patient Safety: In addition to concern over the mental status and physical condition of patients, nursing personnel are concerned with patient safety. Various facilities have implemented policies regarding the use of bedside rails and supervision of patients' smoking habits. These policies are especially important in view of the number of confused patients in nursing homes. Most facilities have more than one policy concerning the use of bedside rails; however, the major reason stated for

their use was that the patient's condition warranted it. Table 51 indicates policies for using bedside rails in nursing homes. It is interesting to note that side rails were used routinely for all patients and not for confusion only.

The legal implications were emphasized by several respondents, who qualified their use for all patients by stating that they were not used if a release was signed by the physician and the patient's family.

Like policies on bedside rails, many facilities had more than one policy concerning smoking privileges. Table 52 shows that one facility allowed patients to smoke in any area, without supervision. The majority of facilities allowed smoking with supervision; many, however, did not allow smoking after bed time. One facility allowed smoking out of doors (weather permitting), another allowed only competent patients to smoke, a third made every effort to encourage patients to stop smoking.

Rehabilitation: An integral aspect of patient care, especially for the aged, is the amount of rehabilitation patients receive. Many nursing homes provide physical and occupational therapy, while few provide speech therapy services. However, patient use of these services is minimal in both types of nursing homes. That is, less than half of the patients in nursing homes where these services are available used them. More patients were using occupational therapy than physical therapy, particularly in proprietary homes (Table 53).

These responses were not given by the actual ward personnel, therefore they may not accurately reflect the actual services provided, if the nursing staff provided them on the wards. However, the minimal use indicated raises several questions: How many need it? Are physicians' orders required? How much therapy is given by the nursing staff—since many of the facilities did not have full time therapists? How much time do these therapists spend in the facilities teaching the nursing staff? Are nursing staff time allocations directed in other areas so that they are unable to provide any of these services?

Recreation: In addition to rehabilitation services, provisions for recreation are included in most nursing homes. While television, current magazines, and daily newspapers were the major forms of recreation provided, many facilities offered recreational programs such as bingo, parties, singing, movies and a variety of entertainment programs. Staff members were primarily responsible for planning the programs. Other personnel involved were administrators, directors of nursing, social workers, activity directors, recreational and occupational therapists, ladies auxiliary, and family and friends.

Tables 54 and 55 indicate the major forms of recreation offered and those responsible for planning it.

Community Involvement through Volunteers: Some of the facilities utilized more than one type of volunteer; however, the three major sources for

volunteers were church groups, women's groups, and candy strippers. Some facilities had no volunteer workers (Table 56).

Other volunteers included Red Cross, residents of a retirement home, private community organizations such as musical groups, librarian and scouting groups, and the county bookmobile.

Table 57 shows the activities of volunteers working in nursing homes. Most of the activities consisted of visiting patients, reading to them, and conducting recreational programs. Few volunteers pushed gift carts or fed patients.

Other involvements included crafts, physical therapy social services, religious services, removing meal trays and making small gifts for birthdays and holidays.

D. Problems that Affect Patient Care.

Equipment and Supplies: A shortage of equipment or supplies is not only frustrating to nursing personnel but also a deterrent to adequate patient care. Nursing time is often wasted searching for supplies or improvising equipment when it is not available. Table 58 shows that the major shortage was linens, followed by wheelchairs. No one reported a shortage of syringes or paper cups, but proper sized catheters and suction machines were added.

The respondents were also asked to indicate which of the above they considered the number one shortage in each of their facilities. Few specified this, but their responses are shown in Table 59.

Other Problems

The problems involved in giving patient care in nursing homes are many and varied. The responses to this question were dichotomized into "Most Important" (1-5) and "Less Important" (6-10) (Table 60). Both types of agencies ranked too much paper work as being the most important problem with lack of money being second in importance. There were no appreciable differences demonstrated between the two types of agencies in the rank order of the other categories of problems.

Other problems included: duplicated, uncoordinated inspection visits; conflicting interpretations by inspectors; unrealistic set-fee basis by Medicaid and reimbursement problems; unrealistic levels of care that dehumanize people; problems with families; lack of community and family involvement; and lack of fringe benefits in a county facility.

SUMMARY AND CONCLUSIONS

Questionnaires were sent to the 158 licensed facilities (except domiciliaries) in the state of Maryland. Ninety-four replies were received. The respondents were primarily directors of nursing (not all were RNs, however) in the 41-50 age group. Levels of education of the respondents varied from less than a high school education to a Bachelor of Science in Nursing degree. The majority were RNs with no further preparation. The majority of the administrators and the directors of nursing had been in their positions for more than 3 years, indicating a fair amount of stability at these levels.

A profile of the facilities and their populations revealed that they were primarily skilled care or intermediate long-term type A facilities with a predominance of white females who were either private patients or who received benefits from Medicaid.

Admission to the facilities was based primarily on the individual's disease and, to a lesser extent, on whether or not complicated or extensive treatment was required. Because of licensing requirements, these could be justifiable criteria. Other criteria, especially noisiness, but also including payment problems, confusion and incontinence, also restricted admissions.

The following statistically significant differences between proprietary and non-proprietary facilities were found:

- 1) Proportionately, there were more non-white patients in the non-proprietary facilities and more white patients in the proprietary facilities;
- 2) Medicaid and private patients were primarily white females in proprietary facilities.
- 3) Proportionately, there were more full-time RNs and LPNs in the non-proprietary facilities and, conversely, more full-time aides and male attendants in the proprietary facilities. When part-time personnel were considered, however, the opposite held true: Proportionately, there were more part-time RNs and LPNs in the proprietary facilities and more part-time aides and male attendants in the non-proprietary facilities.

In all other aspects of the study, the differences between the two types of facilities were not statistically significant.

In relation to staffing, the average number of patients assigned to nursing personnel giving nursing care were 6 to 10 on the day and evening shifts during the week and 11 to 5 on the day and evening shifts on the weekends. Assignment of patient care was accomplished primarily through master assignment sheets.

The problem of absenteeism on any of these shifts was denied by almost all of the few who answered this question. This finding however, contrasts

with the view of nursing personnel involved in a recent workshop who considered absenteeism in these facilities a great problem.

In a 24-hour period, RN coverage averaged 14.9 hours and LPN 12.7 hours; there was not RN/LPN coverage for an average of 7 hours. This response did not permit 24-hour summation.

Turnover rates of staff ranged from zero to 100 percent, but usually they fell into the zero to 25 percent range. This, again, is in contrast to the views of participants in the recent workshop for nursing personnel in nursing homes facilities—there, turnover rates of staff were considered a great problem.

Although the responsibilities for patients were assumed primarily by RNs and LPNs, in many facilities all nursing personnel and administrators assumed charge responsibilities in the nursing office, and all nursing personnel assumed charge responsibilities on the wards.

Medication was administered primarily by RNs and LPNs, although in some facilities this function was carried out by specifically trained personnel. All respondents denied that untrained personnel administered medication. When a patient suffered side-effects from medication, anyone on the health team could assume the responsibility of notifying the physician. This raises the questions of how gross these side-effects must be in order to be recognized and how quickly they are recognized. Perhaps the role of the administrator, unless he is also an RN, is not to recognize them, but only to notify the physician upon the request of nursing personnel. The aides, however, are in a different position, since they are the primary providers of patient care. It is not realistic or in the interests of the patients to expect them to have the body of knowledge necessary to recognize symptoms and to make accurate judgments about those symptoms. However, if aides are the only nursing personnel available, then they must carry out this function.

Most physicians saw their patients and renewed medication orders once a month, but between visits they were sometimes difficult to reach. In the workshop mentioned above, the unavailability of physicians was also considered to be a great problem.

Physicians are responsible for the diagnosis and management of their patients, but nursing personnel are responsible for day-to-day nursing care. While conditions change less rapidly in this type of patient population than they do in the acutely ill patient population, it is inevitable that problems will arise that cannot or should not wait for a decision. Yet the majority of the respondents felt that monthly visits of physicians were adequate, and only eleven nurses felt that there were judgments they were capable of making that were now being made by physicians. Almost all of the judgments mentioned fell into the realm of nursing decisions about nursing care.

Very few of the respondents felt that the policies and practices of the

facility had violated good nursing practice. Those who did respond affirmatively stated they had taken action, but no one defined the nature of these actions.

Opinion was fairly evenly divided on the adequacy or inadequacy of inservice education programs. In the majority of the proprietary facilities, only 0 to 2 hours a week were spent in patient-care planning conferences, while in the majority of non-proprietary facilities, an average of 2 to 4 hours were spent in this activity. There are more aides than any other kind of nursing personnel employed in these facilities, and they are the primary providers of patient care. At the same time, they are the least trained to carry out these functions. Understanding the sleep-wake patterns of elderly people, the problems of incontinence and how they can be alleviated to some extent, or the consequences of sensory deprivation cannot be learned merely by giving bedside care. Those in the nursing profession have a moral obligation, not only to keep themselves abreast of the current knowledge in gerontological nursing, but to also impart this knowledge to other members of the health team if they are to do more than pay lip-service to patient-centered care and consideration of the patient as an individual. The importance of inservice education and patient care conferences are emphasized when the specific needs of the patient population are considered.

Over 50 percent of the patients required assistance with ambulation, over 80 percent required partial or complex personal care, and approximately 81 percent were incontinent of bowel or bladder or both. Only in feeding themselves were the majority of patients capable of functioning independently. Over 50 percent of the patients were confused, in almost 55 percent of the proprietary facilities and in 27 percent non-proprietary facilities. Medications and restraints were the major nursing interventions used. The amount of nursing care and the skills and knowledge required for this kind of care cannot be minimized.

There is increasing evidence that loss of independence, incontinence, and mental confusion are often the result of the environment, the patient's loss of self-image, and the attitudes and knowledge of the nursing staff. These conditions are reversible with proper nursing management, a proper philosophy of rehabilitation, and meaningful socialization for the patients.

In line with this, increasing evidence indicates that the traditional patterns of patient care in nursing home facilities should be abandoned in favor of schedules that more nearly meet the living patterns and needs of older people.

Decubiti presented less of a problem. While prevention, and treatment when necessary, would seem to be a nursing intervention, in most instances the physician was notified and prescribed treatment.

Side rails were used primarily when the patient's condition warranted it, and the majority of the facilities allowed smoking only with supervision.

Patient use of physical therapy, occupational therapy, and speech therapy were minimal, even when these services were provided.

Television, current magazines, and daily newspapers were the major forms of recreation provided, although a variety of planned programs were offered. These were primarily planned by staff members.

Church groups, women's groups, and candy strippers were the three major sources of volunteers. Twelve facilities had none.

Most patients died. Very few were discharged to homes or other facilities; the two reasons being that either the patient had no family or the family was unwilling to care for him.

Eighteen percent of the patients were capable of administering their own medications, although in some facilities this was not allowed.

The majority of the respondents felt that fewer than 5 percent of their patients would be capable of living in their homes if proper resources and people were available to provide support services.

For those patients who were discharged, planning for continuity of care into the home took place primarily with the physician and the patient's family.

Public health personnel who have been identified as appropriate persons to help the family effect a smooth transition and meet problems that might arise were among the least consulted for this planning.

Linen and wheelchairs were the main shortages that affected direct patient care. Other problems, affecting care indirectly, were too much paper work and lack of money. Many respondents added that duplicated uncoordinated inspections, conflicting interpretations by inspectors, reimbursement problems, and unrealistic levels of care were also problems.

RECOMMENDATIONS

Some of my recommendations are not based on the findings of the study but on questions it raised. Nurses *must* be more responsible for the needs of the elderly and for planning for these needs. They should be involved at the planning and policy levels and should then be involved in making these decisions operational.

- 1) Nurses need to be able to differentiate between nursing care interventions and medical care interventions and be able to prescribe for those that are nursing care.
- 2) The traditional patterns of care that are geared to acute care facilities should be reviewed, and patterns of care that are designed to meet the needs of the elderly in nursing home facilities should be developed.
- 3) The time allocated to inservice education programs and patient care conferences should be increased and their relevance to increasing the quality of patient care reviewed. Emphasis should be placed on, among other things:
 - a. understanding patterns of communication with the elderly
 - b. increasing the independence of patients
 - c. the physiological and other causes of mental confusion
 - d. bowel and bladder training programs
 - f. the philosophy and importance of rehabilitation
 - g. the process of aging
 - h. how the attitudes and knowledge of the nursing staff affect all of the above.

Nurse consultants from the state and local governments, from nursing organizations, and from other sources should be actively involved in assisting facilities with these programs for all shifts of personnel.

- 4) Since all members of the health team, regardless of preparation, are making decisions, it is important that the supervisory level nurses have a higher level of assessment skills so that they have the knowledge to collaborate with the physicians on decisions. The supportive level of nurses, through inservice education and supervision, should develop the skills that permit them to decide that help is needed.
- 5) Increase the actual patient use of physical, occupational, and speech therapy. Therapists in the facilities or consultants should be responsible for:
 - a. implementing this aspect of care
 - b. communicating to the nursing staff what is being done for the individual patient
 - c. teaching the nursing staff therapy that could be carried out at the bedside.

- 6) The findings of the study indicated that more patients could live at home than could take their medications at home; therefore, do some of the nursing home practices contribute to dependence and deterioration rather than independence?
- 7) Objective reevaluation of the patient population to determine if any of them would be capable of living in their own homes if the proper support services were available. This would also necessitate a review of all of the available community resources to determine how responsive and committed these agencies are to helping patients live in the community and if their services are available to all of the population in need of them.
- 8) Use of these facilities by students from the various levels of nursing programs. The "crosscultural" contacts between staff and students could be valuable and stimulating for all involved, including the patients.
- 9) Review, and revision as necessary, of recreational programs to ensure that they are providing socialization. This might include considering the recruitment of volunteers who would and could provide a sustained, one-to-one relationship with selected patients.
- 10) Review of the rules and regulations of licensure in order to coordinate inspections, develop consistent interpretations, and evaluate records that are required.
- 11) Because there is no tool to measure the actual quality of patient care given, and because some of the questions in this study could be responded to with socially desirable answers, further studies should be conducted; these should involve direct observations and interviews with nursing personnel, patients, and families.

REFERENCES

1. *Regulations Governing Nursing Homes*, Department of Health and Mental Hygiene, State of Maryland, 1969.
2. I gratefully acknowledge the guidance and support of Paul Ephros, Ph.D., associate professor, University of Maryland School of Social Work and Community Planning; Arlene Mitchell, RN, Ph.D., director of research, School of Nursing, University of Maryland; Nancy Wilkey, RN, MSN, assistant professor, School of Nursing, University of Maryland; and Kathleen Burke, RN, MSW, instructor, School of Nursing, University of Maryland.

This report was prepared for the Commission by Phyllis Nye.

APPENDIX: NURSING SURVEY

1. Your position in this facility is: (check one)

- | | | |
|------------------------|----------------|--------------------|
| 1. director of nursing | 3. staff nurse | 5. aide |
| 2. supervisor | 4. LPN | 6. other (specify) |

2. Your age is: (check correct answer)

1. 21-30 2. 31-40 3. 41-50 4. 51-60 5. over 60

3. What is your highest level of formal education? (check one)

- | | |
|-----------------------------|-----------------------------------|
| 1. less than high school | 5. bachelor of science in nursing |
| 2. high school | 6. college, but no degree |
| 3. licensed practical nurse | 7. master of science in nursing |
| 4. registered nurse | 8. other (specify) |

4. What type of care is your facility licensed to give? (check all correct answers)

- | | |
|----------------------------|-----------------------------------------|
| 1. chronic care | 3. intermediate long-term care (type A) |
| 2. extended care (skilled) | 4. intermediate personal care (type B) |

5. For how many beds is your facility licensed? _____

6. What is your patient census this date: _____

	<i>Number</i>	<i>Private</i>	<i>Medicare</i>	<i>Medicaid</i>	<i>White</i>	<i>Non-white</i>
Male						
Female						
Total						

7. Give the number of patients this day who are:

- | | |
|-------------------------------------|--------------------------------------------|
| 1. _____ ambulatory | 4. _____ up with walker, crutches, or cane |
| 2. _____ ambulatory with assistance | 5. _____ up in wheelchair |
| 3. _____ up in a chair | 6. _____ confined to bed |

8. Give the number of patients this day who are:

- | | |
|--------------------------------------|------------------------------------|
| 1. _____ incontinent of urine | 4. _____ external urinary catheter |
| 2. _____ incontinent of feces | 5. _____ none of these |
| 3. _____ indwelling urinary catheter | |

9. Give the number of patients this day who:

- | | |
|--------------------------------|------------------------------------------|
| 1. _____ feed selves | 4. _____ unable to take oral nourishment |
| 2. _____ feed selves with help | 5. _____ tube feedings |
| 3. _____ must be fed | |

10. Give the number of patients this day who are:

- | | |
|-------------------------|------------------------|
| 1. _____ self care | 3. _____ complete care |
| 2. _____ care with help | |

Nursing Services in Nursing Homes

11. For which of the following reasons are you particularly reluctant to admit patients to your facility? (check as many as apply)

- | | |
|------------------------|--------------------------------------------------------------------------------|
| 1. Incontinent | 6. Complicated or extensive treatment needed |
| 2. Indwelling catheter | 7. Certain diseases or conditions not accepted |
| 3. Not ambulatory | 8. Patient is ambulatory and facility accepts only wheelchair and bed patients |
| 4. Noisy | 9. Payment problem |
| 5. Confused | 10. Other (specify) _____ |

12. Please give the following information on your staff, including yourself:

	<i>Number of Full Time</i>	<i>Number of Part Time</i>	<i>Average Number of Hours Part Time Personnel Work</i>
RNs	_____	_____	_____
LPNs	_____	_____	_____
Aides	_____	_____	_____
Male Attendants	_____	_____	_____
LPNs by waiver	_____	_____	_____

13. Different facilities have different requirements for RN and LPN coverage. During an average 24-hour period, how many hours does your facility have:

- | | |
|-----------------------|--------------------------------|
| 1. _____ RN coverage | 3. _____ No RN or LPN coverage |
| 2. _____ LPN coverage | |

14. On the weekday that preceeded answering this questionnaire, how many of the personnel scheduled to be on duty actually worked, and how many were absent?

	<i>Charge on Unit</i>		<i>Other RNs</i>		<i>Other LPNs</i>		<i>Other Aides</i>		<i>Male Attendants</i>	
	<i>Work- ed</i>	<i>Absent</i>	<i>Work- ed</i>	<i>Absent</i>	<i>Work- ed</i>	<i>Absent</i>	<i>Work- ed</i>	<i>Absent</i>	<i>Work- ed</i>	<i>Absent</i>
Days	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Evns.	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Nights	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

15. On the weekend (Saturday and Sunday) that preceeded answering this questionnaire, how many of the personnel scheduled to be on duty actually worked and how many were absent?

	<i>Charge on Unit</i>		<i>Other RNs</i>		<i>Other LPNs</i>		<i>Other Aides</i>		<i>Male Attendants</i>	
	<i>Work- ed</i>	<i>Absent</i>	<i>Work- ed</i>	<i>Absent</i>	<i>Work- ed</i>	<i>Absent</i>	<i>Work- ed</i>	<i>Absent</i>	<i>Work- ed</i>	<i>Absent</i>
Days	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Evns.	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Nights	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

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16. Who assumes charge responsibilities in the nursing office at various times? (check as many as apply)
- | | | |
|--------|------------------|--------------------|
| 1. RN | 3. LPN by waiver | 5. aide |
| 2. LPN | 4. administrator | 6. other (specify) |
17. Who assumes charge responsibilities on the ward at various times? (check as many as apply)
- | | | |
|--------|------------------|--------------------|
| 1. RN | 3. LPN by waiver | 5. other (specify) |
| 2. LPN | 4. aide | |
18. What was percentage of turnover in the following positions between January 1, 1971 and January 1, 1972?
- | | |
|------------------------|-------------------------|
| 1. _____ RN | 4. _____ aide |
| 2. _____ LPN | 5. _____ male attendant |
| 3. _____ LPN by waiver | |
19. How long have the following been in their position? (check appropriate answer)
- | <i>Administrator</i> | <i>Director of Nursing</i> |
|--------------------------|----------------------------|
| 1. less than one year | 1. less than one year |
| 2. one to three years | 2. one to three years |
| 3. more than three years | 3. more than three years |
20. Have you updated your knowledge of gerontology within last two years? Yes _____ No _____ (If either yes or no, check all appropriate answers)
- | | |
|--------------------------------|-----------------------------------------|
| 1. course | 4. too busy because of job requirements |
| 2. books and/or journals | 5. other (specify) |
| 3. conferences and/or seminars | |
21. In general, do you feel that most nursing homes have sufficient in-service education? Yes _____ No _____
- Comments:
22. Do you feel your facility has enough in-service education? Yes _____ No _____
- Comments:
23. On the average, how much time does the professional nurse spend per week conducting nursing-care conferences? (check answer that most nearly meets your situation)
- | | | |
|--------------|--------------|----------------------|
| 1. 0-2 hours | 2. 2-4 hours | 3. more than 4 hours |
|--------------|--------------|----------------------|
24. Medications are administered by: (check the one that most nearly meets your situation)

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1. RN
 2. LPN
 3. RN and/or LPN
 4. Not an RN or LPN, but specifically trained personnel
 5. Not an RN or LPN, but untrained personnel
 6. Any one of the above, but at different times
25. Injectable medications are administered by: (check the *one* that most nearly meets your situation)
1. RN
 2. LPN
 3. RN and/or LPN
 4. Not RN or LPN, but specifically trained personnel
 5. Not RN or LPN, but untrained personnel
 6. Any one of the above, but at different times
26. Could any of your patients administer their own medications?
- Yes _____ No _____ Percent that could _____
27. Should a patient suffer side effects from a medication, whose responsibility is it to take appropriate action? (check as many as apply)
1. administrator
 2. director of nursing
 3. RN
 4. LPN
 5. aide
 6. LPN by waiver
28. How often are medications usually renewed? (check the answer that most nearly meets your situation)
1. every 30 days
 2. every 60 days
 3. every 90 days
 4. every 6 months or more
 5. oftener than every 30 days
29. Any type of IV procedure (fluids, medications, blood transfusions) is started by: (check as many as apply)
1. RN
 2. LPN
 3. LPN by waiver
 4. other personnel, specifically trained
 5. other personnel, no training
 6. no one; not done in this facility
 7. other (specify)
30. How are patient-care assignments primarily communicated to the staff? (check as many as apply)
1. individual assignment sheets
 2. master assignment sheet
 3. oral assignment
 4. no assignment necessary because they change infrequently
 5. other (specify)
31. Approximately how many patients are assigned to each person giving nursing care?
1. _____ week days
 2. _____ week evenings
 3. _____ weekend (Sat. and Sun.) days
 4. _____ weekend (Sat. and Sun.) evenings
32. Have there been instances when, in your judgment, policies or practices in your facility have violated good nursing practice? Yes _____ No _____
- Yes _____ No _____
- If yes, did you take action?
33. Do any of the nursing personnel prepare meals? (check one answer)
1. always
 2. sometimes
 3. never

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34. Do any of the nursing personnel launder linen? (check one answer)
1. always 2. sometimes 3. never
35. Do any of the nursing personnel perform regular housekeeping duties? (check one answer)
1. always 2. sometimes 3. never
36. Which of the following do you sometimes find in short supply? (check all that apply and specify which is the No. 1 shortage)
- | | |
|---------------------------------|--------------------------------------------------------|
| a. linen | h. dressings |
| b. syringes | i. side rails |
| c. hydraulic lifts for patients | j. paper cups |
| d. walkers | k. medicine cups |
| e. wheelchairs | l. assessment equipment (BP cuffs, thermometers, etc.) |
| f. commodes | m. between-meal nourishments |
| g. enema equipment | n. other (specify) |
37. Protecting confused patients poses problems for all facilities. Which of the following procedures does your facility customarily employ? (check as many as apply)
- | | |
|--------------------------------|-----------------------------------------|
| 1. restraints | 4. segregate on a certain floor or area |
| 2. medication | 5. allowed to ambulate on unit |
| 3. segregate in a private room | 6. other (specify) |
38. To your knowledge, what percentage of your patients (whether or not they have a diagnosis of senility) are mentally confused? (check one answer)
- | | | |
|--------------|--------------|--------------|
| 1. 0 to 10% | 3. 21 to 30% | 5. 41 to 50% |
| 2. 11 to 20% | 4. 31 to 40% | 6. over 50% |
39. Do you make a written report on the number and condition of decubiti?
- Yes _____ No _____ If yes, to whom?
40. What further action is taken if decubiti are reported?
41. What percent of your patients currently have decubiti?
- | | | | |
|-------------|--------------|--------------|---------|
| 1. 0 to 5% | 3. 11 to 15% | 5. 21 to 25% | 7. none |
| 2. 6 to 10% | 4. 16 to 20% | 6. over 25% | |
42. With whom do you consult in planning for continuity of care when a patient is discharged? (check as many as apply)
- | | |
|----------------------------|---------------------------|
| 1. patient | 5. public health facility |
| 2. patient's family | 6. social services |
| 3. patient's foster family | 7. none |
| 4. physician | 8. other (specify) |

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43. What percentage of your patients cannot be discharged because:

- there is no family to care for them? _____ %
 —family will not care for them? _____ %

44. How do you handle patients who have a mental or physical change in status that requires more care? (check as many as apply)

1. infirmary
 2. transfers to another facility
 3. transfer to greater care area within facility
 4. other (specify)

45. Who can make the decision to call the physician when a patient's status changes? (check as many as apply)

1. administrator
 2. director of nursing
 3. RN
 4. LPN
 5. aide
 6. other (specify)

46. Does your facility provide:

	Yes	No	Full Time	Part Time	Consultant	% of Patients Using
Physical Therapy						
Occupational Therapy						
Speech Therapy						

47. What is your policy on side rails? (check answer that most nearly meets your situation)

1. required for all patients
 2. required for all patients only at night
 3. required for all bed patients at all times
 4. required for all bed patients only at night
 5. required only when patient's condition warrants it
 6. required only when ordered by physician
 7. policy is determined by patient's age
 8. required only for confused patients
 9. never used
 10. other (specify)

48. What is your policy on patients smoking? (check as many as apply)

1. special area only with supervision
 2. special area only with no supervision
 3. patient room only with supervision
 4. patient room only with no supervision
 5. any area with supervision when needed
 6. any area with no supervision
 7. not allowed after bedtime
 8. never allowed
 9. other (specify)

49. What types of physicians are on your staff? (check as many as apply)

1. principal
 2. private
 3. medical director

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50. In your facility, how available are physicians when there is a need to discuss their patients? (check as many as apply)
- | | |
|----------------------------------------------------------------------------|--------------------------------------------------------------------------|
| 1. available only by telephone | 4. supposed to be available personally, but sometimes difficult to reach |
| 2. available personally | 5. never available |
| 3. supposed to be available by telephone, but sometimes difficult to reach | |
51. Are physicians making judgments now that could be made by (check as many as apply)
- | | | | |
|-------|--------|---------|------------------|
| 1. RN | 2. LPN | 3. aide | 4. administrator |
|-------|--------|---------|------------------|
52. How often, on the average, does the principal physician see patients under his care (check answer that most nearly meets your situation)
- | | |
|--------------------------|------------------------------------------------------|
| 1. once a week | 5. sometimes less frequently than once every 60 days |
| 2. once every other week | 6. no principal physician on staff |
| 3. once a month | 7. other (specify) |
| 4. once every 2 months | |
53. How often, on the average, do private physicians see patients under their care (check answer that most nearly meets your situation)
- | | |
|--------------------------|------------------------------------------------------|
| 1. once a week | 5. sometimes less frequently than once every 60 days |
| 2. once every other week | 6. no private physicians |
| 3. once a month | 7. other (specify) |
| 4. once every 2 months | |
54. In your judgment, is the frequency of visits (check one answer)
- | | |
|-----------------------|-----------------------|
| 1. more than adequate | 3. less than adequate |
| 2. adequate | 4. clearly inadequate |
55. As you know, many people feel that given proper support services, some patients could live in the community. If these services, such as Instructive Visiting Nurses Association, homemakers' service, home health aides, meals-on-wheels and day-care centers were available, what percent of your patients, in your judgment, could live in the community (check one answer)
- | | | |
|-----------------|--------------|------------------|
| 1. less than 5% | 3. 11 to 15% | 5. 21 to 25% |
| 2. 6 to 10% | 4. 16 to 20% | 6. more than 25% |
56. What percentage of your patients terminate because of (check the 3 answers that most nearly meet your situation)
- | <i>A. Death</i> | <i>B. Discharge to home or foster home</i> | <i>C. Discharge to greater care facility</i> |
|-----------------|--------------------------------------------|----------------------------------------------|
| 1. 0 to 10% | 1. 0 to 10% | 1. 0 to 10% |
| 2. 11 to 20% | 2. 11 to 20% | 2. 11 to 20% |
| 3. 21 to 40% | 3. 21 to 40% | 3. 21 to 40% |
| 4. 41 to 60% | 4. 41 to 60% | 4. 41 to 60% |
| 5. 61 to 80% | 5. 61 to 80% | 5. 61 to 80% |
| 6. 81 to 100% | 6. 81 to 100% | 6. 81 to 100% |

Nursing Services in Nursing Homes

57. Which of the following does your facility utilize as volunteers (check as many as apply)
- | | |
|------------------------------------|--------------------|
| 1. candy strippers (or equivalent) | 4. no volunteers |
| 2. church-affiliated groups | 5. other (specify) |
| 3. womens' groups in the community | |
58. Which of the following ways describe community involvement in your facility through volunteers? (check as many as apply)
- | | |
|------------------------------------------|--------------------------------------------------|
| a. patient visiting | g. reading to patients |
| b. gift cart | h. feeding patients |
| c. work in gift shop | i. giving patient care |
| d. mending for patients | j. planning & conducting programs/
recreation |
| e. letter writing for patients | k. other (specify) |
| f. transporting patients within facility | |
59. Different kinds of recreation are provided in different facilities. Which of the following are provided in your facility on a regular basis? (check as many as apply)
- | | |
|----------------------|--------------------------------------------------|
| 1. television | 5. outdoor recreation when weather permits |
| 2. library | 6. regularly planned evening or weekend programs |
| 3. current magazines | 7. crafts |
| 4. daily newspapers | 8. trips out of the home |
| | 9. other (specify) |
60. Who is responsible for planning recreational programs? (check as many as apply)
- | | | |
|------------------|-----------------------------|--------------------|
| 1. staff members | 3. anyone who is interested | 5. other (specify) |
| 2. volunteers | 4. no one | |
61. Below is a list of problems you might have in caring for your patients. Rank them from 1 to 10, beginning with the problem you find most difficult.
- | |
|-------------------------------------------------------------|
| a. _____ inadequate physical plant |
| b. _____ inadequate supplies |
| c. _____ inadequate staff |
| d. _____ inadequately prepared staff |
| e. _____ lack of money |
| f. _____ administrative constraints |
| g. _____ lack of empathy for patients |
| h. _____ low staff morale |
| i. _____ too much paper work dictated by legal requirements |
| j. _____ other (specify) |

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TABLE 1. Position of respondents.

Position	Type of facility		Total
	Profit (N=63) (%)	Nonprofit (N=29) (%)	
Director			
Nursing	86.0	79.3	83.6
Supervisor	6.0	10.3	7.7
Administrator	8.0	10.3	8.6
Total	100.0	99.9	99.9

TABLE 2. Age distribution of respondents (N = 92).

Position	Age of respondents (years) and type of facility (%)									
	21-30		31-40		41-50		51-60		60+	
	Profit	Nonprofit	Profit	Nonprofit	Profit	Nonprofit	Profit	Nonprofit	Profit	Nonprofit
Director nursing	12.6	10.3	19	17.2	23.8	27.6	22.2	10.3	7.9	13.8
Supervisor	0	0	1.6	0	1.6	3.4	3.2	3.4	0	3.4
Administrator	0	0	1.6	0	3.2	6.9	1.6	0	1.6	3.4

TABLE 3. Educational level of respondents (N = 94).

Level of education	Type of facility		Total*
	Profit	Nonprofit	
Less than high school	0	2	2
High School	3	1	4
LPN	9	2	11
RN	42	24	66
BSN	5	2	7
College, no degree	10	3	13
Master's	0	0	
Other	4	4	8
Total	73	38	111

*The total number of responses is greater than one sample size because some respondents indicated more than one choice.

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TABLE 4. Length of time in position—administrators ($\chi^2=0.1285$; d.f.=2; $P=n.s.$; χ^2 is appropriate for nominal or ordered data and was done to determine if the differences between the two types of facilities were statistically significant).

Years	Type of facility	
	Profit (N=57) (%)	Nonprofit (N=28) (%)
0-1	5.3	7.1
1-3	24.5	25.
3+	70.0	67.8
Total	99.8	99.9

TABLE 5. Length of time in position—directors of nursing ($\chi^2=2.9891$; d.f.=2; $P=n.s.$).

Years	Type of facility	
	Profit (N=59) (%)	Nonprofit (N=28) (%)
0-1	27.0	14.2
1-3	24.0	39.2
3+	49.0	46.4
Total	100.0	99.8

TABLE 6. Types of facilities (N = 93).

Facility	Profit	Nonprofit	Total
Chronic care	5	3	8
Skilled	35	16	51
Long term			
Intermediate A	47	24	71
Personal			
Intermediate B	4	5	9

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TABLE 7. Reasons for reluctance to admit patients to nursing homes ($N=90$; $\chi^2=11.0034$; d.f.=7; $P=n.s.$).

Criteria	Type of facility		Total
	Profit	Nonprofit	
Certain diseases or conditions not accepted	40	22	62
Noisy	23	17	40
Complicated or extensive treatment	29	10	39
Payment problem	14	6	20
Indwelling catheter	6	4	10
Confused	2	7	9
Not ambulatory	3	4	7
Incontinent	2	2	4
Facility accepts only bed or wheelchair patients		2	2
Total	119	74	193

TABLE 8. Patient distribution by sex and race ($N = 92$; $\chi^2 = 54.6084$; d.f. = 3; $P = <.001$).

Sex and race	Type of facility					Total Patients (No.)
	Profit		Nonprofit		Percent of all patients	
	Patients (No.)	Percent of proprietary	Patients (No.)	Percent of nonproprietary		
White male	883	24.1	15.1	441	20.5	1,324
Nonwhite male	171	4.7	2.9	64	3.0	235
White female	2,348	64.0	40.3	1,559	72.5	3,907
Nonwhite female	266	7.2	4.6	87	4.0	353
Total	3,668	100.0	63.0	2,151	100.0	5,819

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TABLE 9. Medicare recipients ($N = 92$; $\chi^2 = 1.4896$; d.f. = 1; $P = \text{n.s.}$).

Sex	Type of facility		Total
	Profit	Nonprofit	
Male	48	57	105
Female	88	77	165
Total	136	134	270

TABLE 10. Medicaid recipients ($N = 92$; $\chi^2 = 9.001$; d.f. = 1; $P = <.01$).

Sex	Type of facility				Total
	Profit		Nonprofit		
	(No.)	(%)	(No.)	(%)	
Male	628	19.6	279	8.7	907
Female	1,463	45.6	836	26.1	2,299
Total	2,091	65.2	1,115	34.8	3,206

TABLE 11. Private care patients ($N = 92$; $\chi^2 = 14.0908$; d.f. = 1; $P = <.001$).

Sex	Profit		Nonprofit		Total
	(No.)	(%)	(No.)	(%)	
Male	449	17.4	167	6.5	616
Female	1,275	49.3	695	26.9	1,970
Total	1,724	66.7	862	33.4	2,586

TABLE 12. Full-time nursing personnel ($N = 90$; $\chi^2 = 15.9212$; d.f. = 4; $P = <.01$).

Personnel	Type of facility				Total
	Profit		Nonprofit		
	(No.)	(%)	(No.)	(%)	
RN	136	8.5	94	9.6	230
LPN	118	7.4	90	9.2	208
LPN/waiver	18	1.1	28	2.9	46
Aide	1,238	77.7	707	72.6	1,945
Male attendant	83	5.2	55	5.6	138
Total	1,593	99.9	974	99.9	2,567

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TABLE 13. Part-time nursing personnel ($N = 90$; $\chi^2 = 20.7287$; d.f. = 4; $P = <.001$).

Personnel	Type of facility				Total
	Profit		Nonprofit		
	(No.)	(%)	(No.)	(%)	
RN	164	36.1	69	24.7	233
LPN	56	12.3	26	9.3	82
LPN/waiver	4	0.01	5	1.8	9
Aide	190	41.8	162	58.1	352
Male attendant	40	8.8	17	6.1	57
Total	454	99.01	279	100.0	733

TABLE 14. Full- and part-time personnel ($N = 90$; $\chi^2 = 13.4516$; d.f. = 4; $P = <.02$).

Personnel	Type of facility				Total
	Profit		Nonprofit		
	(No.)	(%)	(No.)	(%)	
RN	300	14.7	163	13.0	463
LPN	174	8.5	116	9.3	290
LPN/waiver	22	1.1	33	2.6	55
Aide	1,428	69.8	869	69.3	2,297
Male attendant	123	6.0	72	5.7	195
Total	2,047	100.0	1,253	99.9	3,300

Table 15. Average number of patients per person, full- and part-time.

Personnel	Type of facility	
	Profit (4,512 beds)	Nonprofit (2,278 beds)
RN	15.0	14.0
LPN	25.9	19.6
Aide	3.2	2.6
Male attendant	36.7	31.6

TABLE 16. Average number of hours of RN and LPN coverage in a 24-hour period ($\chi^2 = 0.1333$; d.f. = 2; $P = \text{n.s.}$).

Personnel	Type of facility		Total
	Profit	Nonprofit	
RN	9.5	5.4	14.9
LPN	8.2	4.5	12.7
No RN or LPN	5.0	2.0	7.0
Total	22.7	11.9	34.6

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TABLE 17. Turnover of nursing staff in profit-making facilities from January 1, 1971 to January 1, 1972, ($N = 53$).

Personnel	Turnover in profit facilities (No.)			
	0-25%	26-50%	51-75%	76-100%
RN	10	5	2	3
LPN	9	3	1	3
LPN/waiver	2	1	0	0
Aide	20	8	5	2
Male attendant	8	3	1	3
Total	49	20	9	11

TABLE 18. Turnover of nursing staff in nonprofit facilities from January 1, 1971 to January 1, 1972 ($N = 20$).

Personnel	Turnover in nonprofit facilities (No.)			
	0-25%	26-50%	51-75%	76-100%
RN	6	0	3	0
LPN	4	0	0	2
LPN/waiver	1	1	0	0
Aide	9	6	0	0
Male attendant	5	0	0	3
Total	25	7	3	5

TABLE 19. Charge responsibilities in the nursing office ($N = 93$; $\chi^2 = 1.4668$; d.f. = 3; $P = \text{n.s.}$).

Personnel	Type of facility		Total
	Profit	Nonprofit	
RN	51	25	76
LPN	29	11	40
LPN/waiver	3	1	4
Administrator	27	8	35
Aide	10	3	13
Total	120	48	168

TABLE 20. Charge responsibilities on the ward ($N = 94$; $\chi^2 = 0.3625$; d.f. = 3; $P = \text{n.s.}$).

Personnel	Type of facility		Total
	Profit	Nonprofit	
RN	51	26	77
LPN	49	23	72
LPN/waiver	8	5	13
Aide	19	10	27
Total	125	64	189

Nursing Services in Nursing Homes

TABLE 21. Responsibility for administering oral medications ($N = 91$; $\chi^2 = 0.2835$; d.f. = 2; $P = \text{n.s.}$).

Personnel	Type of facility		Total
	Profit	Nonprofit	
RN	17	7	24
LPN	11	4	15
RN/LPN	30	15	45
Specifically trained person	3	0	3
Untrained person	0	0	0
Any of the above at different times	3	2	5
Total	64	28	92

TABLE 22. Responsibility for administering intravenous medications ($N = 93$; $\chi^2 = 2.4124$; d.f. = 2; $P = \text{n.s.}$).

Personnel	Type of facility		Total
	Profit	Nonprofit	
RN	17	12	29
LPN	9	2	11
RN/LPN	35	14	49
Specifically trained person	3	0	3
Untrained person	0	0	0
Any of the above at different times	0	1	1
Total	64	29	93

TABLE 23. Responsibility of personnel for taking action in the event of medication side effects in patients ($N = 92$; $\chi^2 = 1.2318$; d.f. = 4; $P = \text{n.s.}$).

Personnel	Type of facility		Total
	Profit	Nonprofit	
Director nursing	53	18	71
RN	45	19	64
LPN	38	13	51
Administrator	27	7	34
Aide	11	2	13
LPN/waiver	6	3	9
Total	180	62	242

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TABLE 24. Decision-making responsibilities for physician consultation when patient status changes ($N = 94$).

Personnel	Type of facility		Total
	Profit	Nonprofit	
Director nursing	61	25	86
RN	54	25	79
LPN	51	18	69
Administrator	50	13	63
Aide	7	2	9
Total	223	83	306

TABLE 25. Respondents' perceptions of violations of nursing home policies and practices ($N = 93$).

Choice	Type of facilities		Total
	Profit	Nonprofit	
Yes	5	6	11
No	58	24	82
Total	63	30	93

TABLE 26. Methods for communicating patient care assignments to nursing personnel ($N = 90$; $\chi^2 = 1.6291$; d.f. = 3; $P = \text{n.s.}$).

Assignment	Type of facilities		Total
	Profit	Nonprofit	
Master sheet	31	19	50
Oral	27	14	41
Individual sheet	27	9	36
Not necessary, changes infrequent	6	3	9
Total	91	45	136

TABLE 27. Respondents' perceptions of adequacy of inservice education programs ($N = 63$; $\chi^2 = 1.8389$; d.f. = 1; $P = \text{n.s.}$).

Perceptions	Type of facility					
	Profit		Nonprofit		Total	
	(No.)	(%)	(No.)	(%)	(No.)	(%)
Adequate	26	57.7	7	38.8	33	52.3
Inadequate	19	42.2	11	61.1	30	47.6
Total	45	99.9	18	99.9	63	99.9

Nursing Services in Nursing Homes

TABLE 28. Average hours per week conducting patient care conferences ($N = 89$).

Conference time (hours)	Type of facility	
	Profit ($N = 60$) (%)	Nonprofit ($N = 29$) (%)
0-2	45	38
2-4	30	45
4+	25	17
Total	100	100

TABLE 29. Respondents' sources for updating gerontological practice in the past two years. ($N = 88$; $\chi^2 = 0.1335$; d.f. = 2; $P = n.s.$).

Source	Type of facility		Total
	Profit ($N = 58$)	Nonprofit ($N = 28$)	
Books, journals	53	24	77
Conferences, seminars	45	20	65
Courses	13	7	20
Too busy because of job	1	2	3
Total	112	53	165

TABLE 30. Distribution of physicians in nursing homes ($N = 94$).

Physicians	Type of facility		Total
	Profit	Nonprofit	
Principal M.D.	52	19	71
Private M.D.	52	20	72
Medical director	16	11	27

TABLE 31. Frequency of visits to patients by principal physicians.

Visits	Type of facility	
	Profit ($N = 63$) (%)	Nonprofit ($N = 27$) (%)
Once a week	12.6	7.6
Every other week	3.1	3.8
Once a month	71.4	61.5
Every 2 months	4.7	3.9
Less than every 60 days	3.1	11.5
Other	4.7	11.5
Total	99.6	99.7

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TABLE 32. Frequency of visits to patients by private physicians.

Visits	Type of facility	
	Profit (N = 63) (%)	Nonprofit (N = 27) (%)
Once a week	3.1	
Every other week	1.5	3.7
Once a month	73.0	59.1
Every 2 months	3.1	11.1
Less than every 60 days	7.9	7.4
No private M.D.'s	7.9	14.8
Other	3.1	3.7
Total	99.6	99.8

TABLE 33. Frequency of renewal of medications by physicians.

Renewal of medications	Type of facility	
	Profit (N = 64) (%)	Nonprofit (N = 27) (%)
Every 30 days	76.5	74.1
Every 60 days	1.6	7.4
Every 90 days	14.1	14.8
Every 6 months or more		
More often than every 30 days	7.8	3.7
Total	100.0	100.0

TABLE 34. Availability of physicians ($N = 94$; $\chi^2 = 2.791$; d.f. = 3; $P = \text{n.s.}$).

Availability	Type of facility		Total
	Profit	Nonprofit	
Only by phone	40	15	55
Personally	52	25	77
Sometimes difficult to reach by phone	15	5	20
Sometimes difficult to reach personally	6	6	12
Never available			
Total	113	51	164

Nursing Services in Nursing Homes

TABLE 35. Frequency of meal preparation by nursing personnel.

Frequency	Type of facility		Total
	Profit	Nonprofit	
Always	2		2
Sometimes	5	1	6
Never	56	26	82
Total	63	27	90

TABLE 36. Frequency with which linen is laundered by nursing personnel.

Frequency	Type of facility		Total
	Profit	Nonprofit	
Always	2	1	3
Sometimes	13	2	15
Never	48	25	73
Total	63	28	91

TABLE 37. Frequency of housekeeping duties by nursing personnel.

Frequency	Type of facility		Total
	Profit	Nonprofit	
Always		1	1
Sometimes	21	6	27
Never	43	20	63
Total	64	27	91

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TABLE 38. Patient discharges from nursing homes.

Cause for discharge	Type of facility			
	Profit		Nonprofit	
	(No.)	(%)	(No.)	(%)
Death (%)				
0-10	12	20.7	5	17.9
11-20	7	12.1	5	17.9
21-40	5	8.6	4	14.3
41-60	11	19.0	1	3.6
61-80	4	6.9	3	10.7
81-100	19	32.8	10	35.7
Total	58	100.1	28	100.1
Homes/foster homes (%)				
0-10	32	64.0	9	45.0
11-20	7	14.0	3	15.0
21-40	6	12.0	5	25.0
41-60	4	8.0	2	10.0
61-80	1	2.0	0	0
81-100	0	0	1	5.0
Total	50	100.1	20	100.0
Other facilities (%)				
0-10	34	66.7	15	75.0
11-20	8	15.7	1	5.0
21-40	7	13.7	1	5.0
41-60	1	2.0	1	5.0
61-80	1	2.0	1	5.0
81-100	0	0	1	5.0
Total	51	100.1	20	100.0

TABLE 39. Nursing personnel's perceptions of currently institutionalized patients' ability to live in the community, 1972 ($\chi^2 = 5.5647$; d.f. = 3; $P = \text{n.s.}$).

Percent of patients	Type of facility		Total
	Profit	Nonprofit	
less than 5	38	14	52
6-10	12	3	15
11-15	2	4	6
16-20	2	2	4
21-25	1	1	2
25+	0	6	6
Total	55	30	85

Nursing Services in Nursing Homes

TABLE 40. Respondents' perceptions of patients' abilities to administer own medications in nursing homes.

Perception	Type of facility				Total
	Profit		Nonprofit		
	(No.)	(%)	(No.)	(%)	
Able	8	14.3	7	25.9	15
Not able	48	83.7	20	74.1	68
Total	56	100.0	27	100.0	83

TABLE 41. Patients unable to be discharged because they have no family to care for them or, their family will not care for them ($N = 75$).

Percent of patient	Type of facility			
	Profit		Nonprofit	
	No family	Family will not care	No family	Family will not care
0-25	40	27	12	10
26-50	6	6	4	1
51-75	1	3	1	4
76-100	1	9	3	3
Total	48	45	20	18

TABLE 42. Sources of consultation for patient discharge planning ($N = 93$; $\chi^2 = 3.0529$; d.f. = 6; $P = \text{n.s.}$).

Persons consulted	Type of facility		Total
	Profit	Nonprofit	
Family	57	18	75
Physician	44	19	63
Social services	35	8	43
Patient	29	13	42
Public health facility	22	6	28
Foster family	8	3	11
Other	6	3	9
No one	1	2	3
Total	202	72	274

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TABLE 43. Ambulatory status of patients ($N = 93$).

Status	Type of facility	
	Profit ($N = 3668$) (%)	Nonprofit ($N = 2151$) (%)
Ambulatory	34.9	35.8
Ambulatory assistance	59.9	58.4
Bedridden	5.1	5.8
Total	99.9	100.0

TABLE 44. Patient problems of incontinence ($N = 90$).

Type of facility	Bladder	Bowels	Indwelling catheter	External catheter	Total
Profit	1,551	1,445	340	23	3,359
Nonprofit	618	614	148	11	1,391

TABLE 45. Patients' abilities to manage personal care ($N = 90$).

Type of facility	Self-care (%)	Care with Assistance (%)	Complete care needed (%)
Profit	11.4	41.1	47.5
Nonprofit	14.7	37.5	47.8

TABLE 46. Patients' abilities to feed themselves ($N = 93$).

Ability to feed selves	Type of facility	
	Profit ($N = 3668$) (%)	Nonprofit ($N = 2151$) (%)
Feeds self	68.0	65.0
Needs assistance	31.6	33.8
Tube feeding	0.4	1.2
Total	100.0	100.0

TABLE 47. Respondents' perceptions of number of mentally confused patients.

Percent of patients	Type of facility	
	Profit (N = 62) (%)	Nonprofit (N = 29) (%)
0-10	9.7	17.2
11-20	6.5	6.9
21-30	9.7	3.4
31-40	3.2	13.8
41-50	16.1	31.0
50+	54.8	27.5
Total	100.0	99.8

TABLE 48. Nursing interventions for confused patients ($N = 93$; $\chi^2 = 3.4813$; d.f. = 5; $P = \text{n.s.}$).

Intervention	Type of facility		Total
	Profit	Nonprofit	
Restraint	50	22	72
Medication	49	21	70
Ambulate on unit	24	9	33
Segregate, certain floor or area	16	4	20
Segregate, private room	4	4	8
Other	5	4	9
Total	148	64	212

TABLE 49. Percent of patients with decubiti ($\chi^2 = 1.5257$ (computed from categories 0-5% and 6-10%; d.f. = 1; $P = \text{n.s.}$).

Percent of patients	Type of facility	
	Profit (N = 64) (%)	Nonprofit (N = 26) (%)
0-5	59.3	57.7
6-10	6.3	15.4
11-15	0	3.8
16-20	0	0
21-25	1.6	0
25+	0	0
None	32.8	23.1
Total	100.0	100.0

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TABLE 50. Nursing action taken on patients with reported decubitus ulcers.

Action	Type of facility		Total
	Profit (N = 51)	Nonprofit (N = 23)	
Follow M.D.'s orders	38	14	52
Air mattresses	2	2	4
Medications	4		4
Change position in bed	2	1	3
Total	46	17	63

TABLE 51. Policies for using bedside rails ($N = 94$; $\chi^2 = 7.5241$; d.f. = 5; $P = \text{n.s.}$).

Policy	Type of facility		Total
	Profit	Nonprofit	
Patient condition warrants use	33	14	47
All patients	22	12	34
All bedridden patients at all times	21	7	28
M.D.'s orders	7	3	10
All patients at night	2	4	6
All bedridden patients at night	1	3	4
Determined by patient's age	3	1	4
Confused patients only		1	1
Total	89	45	134

TABLE 52. Patient smoking policies ($\chi^2 = 5.3318$; d.f. = 5; $P = \text{n.s.}$).

Policy	Type of facility		Total
	Profit	Nonprofit	
Special area, with supervision	43	20	63
Not allowed after bedtime	24	8	32
Patient room, with supervision	14	3	17
Any area, with supervision if needed	13	4	17
Special area, no supervision	8	8	16
Never allowed	3	2	5
Patient room only, no supervision	1	2	3
Any area, no supervision		1	1
Total	106	48	154

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TABLE 53. Patient utilization of rehabilitation service ($N = 92$).

Therapy	Type of facility and patients (%)			
	Profit		Nonprofit	
	0-49%	50-100%	0-49%	50-100%
Physical	28	1	8	2
Occupational	18	12	10	3
Speech	10		2	
Total	56	13	20	5

TABLE 54. Types of recreation offered to patients ($N = 94$; $\chi^2 = 2.708$; d.f. = 8; $P = \text{n.s.}$).

Recreation	Type of facility		Total
	Profit	Nonprofit	
Television	64	28	92
Magazines	57	28	85
Newspapers	55	28	83
Crafts	42	25	67
Outdoor	38	18	56
Planned programs	31	20	51
Library	34	16	50
Trips	30	15	45
Other	14	4	18

TABLE 55. Personnel responsible for planning recreational programs ($N = 93$; $\chi^2 = 2.3277$; d.f. = 3; $P = \text{n.s.}$).

Personnel	Type of facility		Total
	Profit	Nonprofit	
Staff	45	12	55
Volunteers	22	10	32
Other	17	10	27
Anyone interested	9	4	13

TABLE 56. Types of volunteers working in nursing homes ($N = 93$; $\chi^2 = 3.0636$; d.f. = 3; $P = \text{n.s.}$).

Volunteer	Type of facility		Total
	Profit	Nonprofit	
Church groups	54	21	75
Women's groups	38	19	57
Candy strippers	14	9	23
Other	7	7	14
None	10	2	12

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TABLE 57. Activities of volunteers working in nursing homes ($N = 93$; $\chi^2 = 2.61$; d.f. = 8; $P = \text{n.s.}$).

Activities	Type of facility		Total
	Profit	Nonprofit	
Visiting patients	58	28	86
Planning Recreational programs	46	25	71
Reading to patients	33	18	51
Writing letters	28	12	40
Transporting patients	22	13	35
Mending clothes	14	12	26
Feeding patients	14	9	23
Gift cart	9	6	15
Other	4	3	7

TABLE 58. Supply shortages in nursing homes.

Supplies	Type of facility		Total
	Profit ($N = 48$)	Nonprofit ($N = 24$)	
Linen	16	7	23
Wheelchairs	9	6	15
Commodes	4		4
Between-meal nourishments	2	2	4
Hydraulic lifts	2	2	4
Assessment equipment	3		3
Side rails	2	1	3
Medicine cups	2	1	3
Walkers	2		2
Enema equipment	1		1
Dressings	1		1
Syringes			
Paper cups			

TABLE 59. Number-one shortage of supplies ($N = 29$).

Supplies	Type of facility		Total
	Profit	Nonprofit	
Linen	8	6	14
Wheelchairs	6	2	8
Lifts		2	2
Commodes	2		2
Side rails	1	1	2
Between-meal nourishments		1	1

Nursing Services in Nursing Homes

TABLE 60. Nursing home problems affecting patient care ($N = 80$).

Problems	Most important (%)		Less important (%)	
	Profit ($N = 243$)	Nonprofit ($N = 71$)	Profit ($N = 95$)	Nonprofit ($N = 38$)
Too much paper work	34.3	31.0	4.2	2.6
Lack of money	17.5	19.7	5.3	5.3
Inadequate staff	11.9	9.8	6.3	5.3
Inadequate physical plant	9.1	9.8	11.6	10.5
Inadequate prepared staff	9.8	9.8	7.4	5.3
Lack of empathy	4.2	4.3	12.6	18.4
Administrative constraints	3.5	1.4	14.7	18.4
Inadequate supplies	2.1	4.3	16.8	13.2
Low staff morale	2.8	5.6	15.8	7.9
Other	4.9	4.3	5.3	13.2

Nursing Home Ownership Patterns in Maryland

INTRODUCTION

The nursing-home industry is increasingly becoming an area of vital public concern. As more and more people live longer, an increasing number find themselves with limited resources, often poor or living on public funds, ending their days in nursing homes.

Those who run the homes are therefore gaining influence over more and more people, and receiving ever-growing amounts of public monies: A fortune in public dollars is being spent on nursing homes. Both federal and state governments reimburse nursing homes for much of the money they spend and the tax-paying public is, therefore, concerned. Nursing home costs should be fully justified and carefully audited. There are many questions as to whether they now are.

This report is the result of searches of corporate charter records, of land records in every county court house in the state, and of the annual statements all corporations must file with the Maryland State Department of Assessments and Taxation. This profile looks at who owns what in the nursing-home industry.

I. Multiple or Interlocking Ownership: Approximately 60 percent of the nursing homes in Maryland are the single home, single owner, often marginal operation most often deplored when the conditions under which the aged are forced to live are examined. Stringent regulations will probably be required before conditions in such homes can be improved.

Of most concern here, however, is the ownership pattern evident in the other approximately 40 percent homes in Maryland, which are not single owner, single establishment. They are generally two, three, four, or even fifteen to a group. Multiple ownership has proliferated only within recent years, since the American government began providing significant sums of money to take care of the aged. This study will not, in itself, yield firm conclusions on the business aspects of corporate ownership of nursing

homes—especially chains—but it seems clear that multiple ownership allows full tax benefits for depreciation of assets and inter-corporate transfer of equipment. It must be kept in mind, however, that everything reported in this study is probably perfectly legal. Indeed, the tax and reimbursement laws not only allow, but encourage, complex corporate arrangements.

There are 147 proprietary nursing homes in Maryland. Sixty-four of these are controlled under multiple-ownership arrangements; 28 are owned by only three corporations.

One of these, Community Health Facilities, has also formed four subsidiary corporations which handle ancillary functions such as medical and hospital supplies. The three corporations and the nursing homes they own:

Community Health Facilities:

- Annapolis Nursing and Convalescent Center
- Bel Air Nursing and Convalescent Center
- Bent Nursing Home
- Bolton Hill Nursing and Convalescent Center
- Foxleigh Nursing Home
- George Washington Nursing and Convalescent Home
- Harbor View Nursing and Convalescent Center
- Harford Gardens Nursing and Convalescent Center
- Lake Drive Nursing Home
- Melchor Nursing Home
- North Arundel Convalescent Center
- Park Hill Convalescent Home
- Pikesville Nursing and Convalescent Center
- Pine Ridge Nursing Home

The four subsidiary corporations:

- Extendicaid of South Baltimore, Inc.
- Green-Ann Medical Properties, Inc.
- Medical Properties, Inc.
- Plan for Retirement, Inc.

Medical Services Corporation:

- Caton Manor Nursing Center
- Frederick Nursing Center
- Hamilton Nursing Center
- Hammonds Lane Nursing Center
- House in the Pines—Bel Aire
- House in the Pines—Belvedere
- House in the Pines—Catonsville
- House in the Pines—Easton
- Long Green Nursing Center
- Randallstown Nursing Center

Manor Care, Inc.:

Manor Care—Adelphi
Manor Care—Ruxton
Manor Care—Towson
Colton Manor, Inc.
Hyattsville Nursing Home
Wheaton Nursing Home

Thirty-six more homes are owned by 13 corporations or groups. Each corporation or group owns at least two, and often three, nursing homes. Two or three own four homes. The 13 corporations or groups, and their homes:

<i>Nursing Home</i>	<i>Owners or Directors in Common</i>
Colonial Nursing Home Sligo Gardens Nursing Home	Gerald Williams, Evelyn Williams, Ronald Senseman
Century Home, Inc. Midtown House, Inc.	Oscar Newman, Beatrice Newman, Anne Newman, Ilene Newman, Julia Perle
Garrison Nursing Home Clifton Domiciliary Home	Hazel Williams, Alton Friend, Teresa Friend
Bethesda-Silver Spring Home Fairland Nursing Home The Westwood	Jerry Sack, Sydney Polakoff, Her- man Sack, Semilia Sack, Dolores Polakoff
Caton Ridge Nursing Home Shangri-La Nursing Home Dulaney Towson Nursing and Convalescent Home	Joseph Loveman, Charles Loveman, Isadore Halikman, Melvyn Pugatch, Leonard Golombek
Madison Manor Nursing Home Randolph Hills Nursing Home	Ellis Duke, Harvey Wertlieb
Windsor Rest Home Lincoln Memorial Nursing Home Granada Nursing Home	Margaret Wessels, Asa Wessels, Robert DeFontes, Hollis Seunarine
Milford Manor Nursing Home Friedler's Guest House	Ellis Friedler, Rose Friedler, Carl Friedler
Hillhaven Nursing Home Paint Branch Nursing Home, Inc.	Cleo Smith, Grace Smith
Brooke Grove Nursing Home Sharon Nursing Home Althea Woodland Oakhaven Care Home	Carl Howe, Eleanor Howe, Karen Firing, Melvin Haas, Howard Morse

Gould Convalesarium Hilton Nursing Home	Milton Gould, Ruth Gould
Chapel Hill Convalescent Home Armacost Nursing Home Randallstown Convalescent Center Grosvenor Lane Nursing and Convalescent Center	W. James Hindman, Richard Heacock, Dixie Hindman, Lorraine Raffel, Richard Young, Margaret Young, Leslie Berman, Normal Geller
Edgewood Nursing Home Perring Parkway Nursing Home	Mark Rosenberg, Carol Rosenberg, Leonard Berger

Each of the three largest corporations is also controlled by a small group of people. Therefore, although the name of each nursing home in each of the three groups is different, all nursing homes owned by each of the three corporations are actually controlled by small groups. What looks like many companies on paper can therefore generally be traced back to the same small group of names. Those controlling each major corporation:

Community Health Facilities and all its subsidiaries: Richard Rynd, Joseph Francus, Edward Sientz, Wilfred Azar, Howard Wagonheim, Millard Buxbaum, E. James Kuhns, Charles Cox, Floyd Abraham.

Medical Services Corporation: Allan Zalesky, Roger Lipitz, Michael Batza, Earl Linehan, David Harans, Malcolm Berman, Raymond Damazo, James Frenkil, E. A. Bertorelli.

Manor Care, Inc.: Steward Bainum, Alma Johnson, Herbert Colton, Fred Ellrod, Dorothy Fincher, Hamilton Boykin, Rosemary Riley.

II. Real Estate Ownership: Complex corporate arrangements are endemic to nursing homes in Maryland. They enable small groups to control many nursing homes and to own the property on which they are located under separate corporate names. When costs, reimbursed by either the state or federal government are figured, separate corporate ownership of homes and land can add up to a sizable reimbursed dollar figure for rent.

The business transactions look like this: A corporation—which can be owned by a small group—is formed to run the home and a separate corporation is formed to own the property which then signs a long-term lease with the corporation—owned by the same small group—running the home. Rent, of course, is a reimbursable cost to the nursing home. The corporation owning the real property then takes the tax depreciation on the land and the deduction of mortgage interest and property tax for purposes of figuring taxable net income. This splits the total income between two corporations keeping net income in a lower corporate tax bracket.

Such ownership structures make the task of finding out who holds an interest in the home, and the extent of their interest, difficult to ascertain. It

was determined, however, that these nursing homes have such paper property arrangements:

Althca Woodland
Annapolis Nursing and Convalescent Center
Armacost Nursing Home, Inc.
Ashburton Nursing Home
Avalon Manor, Inc.
Bay Manor Nursing Home
Bel Air Nursing Home
Bel Pre Health Center
Bolton Hill Nursing and Convalescent Center
Brookfield Manor Nursing Home, Inc.
Caton Ridge Nursing Home
Century Home, Inc.
Clifton Domiciliary Home
Crawford Retreat
Dulaney Towson Nursing Home
Edith A. Anderson Nursing Home
Fairland Nursing Home
Frederick Nursing and Convalescent Center
Glasgow Nursing Home, Inc.
Gould Convalesarium
Granada Nursing Home
Harbor View Nursing and Convalescent Center
Harford Gardens Nursing and Convalescent Center
Hilton Nursing Home
Holly Hill Manor, Inc.
Hyattsville Nursing Home
Ivy Hill Nursing and Convalescent Center
Kensington Gardens Nursing Home
Key Circle Hospice
Knollwood Manor, Inc.
Lake Drive Nursing Home
Lincoln Memorial Nursing Home
Manor Care—Adelphi
Manor Care—Ruxton
Manor Care—Towson
Magnolia Gardens
Melchor Nursing Home
Midtown Nursing Home
Paint Branch Nursing Home
Park Hill Convalescent Home
Perring Parkway Nursing Home

Potomac Valley Nursing Home
Professional House, Inc.
Pullen Nursing Home
Randolph Hills Nursing Home
Salisbury Nursing Home
Shangri-La Nursing Home
Sharon Nursing Home
Suitland Nursing Home
Windsor Nursing Home

III. **Real Estate Corporations:** Following is a list of some of the corporations whose sole function is to hold the real property for nursing homes, and the persons who run these corporations:

West Read Properties, Inc.	Charles Levanan, Malvyn Pugatch, Leonard Golombek
Trison, Inc.	Frank Damazo, Herbert Damazo, Raymond Damazo
North East Nursing Home, Inc. North West Nursing Home, Inc.	Allan Zalesky, Roger Lipitz, Michael Batza, Earl Linehan, David Harans, Malcolm Berman, Ray- mond Damazo, James Frenkil, E. A. Bertorelli
Distco, Inc. Stewall Corporation	Stewart Bainum, Wallace Johnson, Alma Johnson, Herbert Colton, Fred Ellrod, Hamilton Boykin, Rosemary Riley, Dorothy Fincher
3313 Realty Corporation 6116 Realty Corporation	Mitchell Gould, Ruth Gould

Some of the nursing homes listed in Section III require special explanation. Their property is not owned by a separate corporation, but rather by individuals, most often the same persons who run the corporation which runs the home. This method is generally found where not more than two or three homes are owned; it retains much of the advantages of the two-corporation set-up.

IV. **Principal Physician:** The questions raised by the investigation of the Gould Convalesarium tragedy extended beyond the question of ownership. The investigative committee of the Maryland Medical and Chirurgical Faculty, for example, found that there was no real way to put responsibility for health conditions in nursing homes on the doctors listed as principal physicians. There was also no way to enforce any of the duties assumed to

be the principal physician's. A question was raised about the propriety of a physician taking on the responsibilities of principal physician in more than one home, which could result in their attention being so widely dispersed that they might not be alert to dangerous conditions in any one nursing home. These are physicians listed as principal physician for more than one nursing home:

Willard Applefeld	Abraham Hurwitz
Albert Bradley	James Kerr
Cesear Cavere	C. H. Ligon
Anthony Carozza	Harold Plummer
Bernard Fitzgerald	Hollis Seunarine
Richard Hechman	Manuel Levin
Richard Hunt	Loy Zimmerman

V. Physician Ownership: Many Maryland physicians have financial interests in nursing homes. There is nothing in the medical code of ethics to prevent or deplore this practice. It does seem, however, to place the patient, old, often confused, often poor, often not fully capable of looking out for his or her interests effectively, up against rather strong financial interests.

Physicians who have ownership interests in nursing homes or nursing-home connected corporations, or nursing-home connected real estate corporations, are as follows:

<i>Physicians</i>	<i>Nursing Homes</i>
Leonard Golombek	Dulaney Towson Nursing Home
Frank Damazo	Cumberland Nursing and Convalescent Home
Joseph Weber	Suitland Nursing Home
Osman Ersby	Calvert House Corporation
Roland White	Eventide Care Home
Jaun Machado	Suitland Nursing Home
H. Talbott Bruce	Vindabona Nursing Home
Thomas Harris	Clifton Domiciliary Home
N. A. Harris	Clifton Domiciliary Home
John Holmes	Clifton Domiciliary Home
Arthur Levitsky	Brevin Nursing Home
Henry Lowden	Carroll Hall Sanitarium
Howard Morse	Althea Woodland; Brooke Grove Nursing Home
Louis Schoolman	Vindabona Nursing Home
Hollis Seunarine	Granada Nursing Home
Percival Smith	Clifton Domiciliary Home
James Frenkil	Medical Services Corporation homes
Peter Fahrney	Vindabona Nursing Home

George Weems	Calvert House Corporation
Leonard Berger	Edgewood Nursing Home; Perring Parkway Nursing Home
Richard Young	Armacost Nursing Home

VI. **Pharmacists' Interests in Nursing Homes:** Pharmacists also can be found following the same patterns as physicians: Serving more than one nursing home and having financial interests in nursing homes to which they sell supplies. Here again there is nothing in any code of ethics to forbid or even frown on these practices, but questions should be raised by them. What financial benefits are there for a pharmacist in serving more than one home? How do drug companies respond to the large volume of business such service may engender? Again there are no specific answers immediately available, but these are issues with which regulatory agencies or the legislature may wish to concern themselves.

One pharmacist, Accredited Surgical Company (which serves many homes in the greater Washington area) maintains a lobbyist in the Maryland legislature, is active in Health Facilities Association of Maryland, a nursing-home lobbying group. These pharmacists who serve more than one nursing home:

Accredited Surgical Company	Lawson's Pharmacy
Heneson's Pharmacy	Northern Pharmacy
Herbert Damazo	Southgate Pharmacy
Joseph Getka	Zentz Pharmacy
Harold Kramm	James Truitt
Howard and Morris	

These pharmacists who own or direct a nursing home:

Herbert Damazo	Cumberland Nursing Home
	Frederick Nursing & Convalescent Center
Joseph Getka	Paradise Nursing Home
Arthur Levin	Brevin Nursing Home

VIII. **Conclusions:**

This report has attempted to point out how nursing homes and the property they rest upon are owned, who owns them; who are the physicians and pharmacists involved in the homes; and some of the interlocking interests. It raises the fundamental question of the relationship of ownership structure to quality of care. We have fostered larger, more distant and less human structures and we must understand the result. Has the quality of care for the individual aged person become more humane? Or, just more efficient? If so, what is the proper response in view of the fact that some, if not many, of these pressures toward super corporateness are from societal factors more powerful than the regulatory power of agencies in this field?

This study was compiled from data gathered from: Literature of the homes themselves; a list (which was as current as available, yet several years old and incomplete) of those holding a 10 percent or greater interest in each home; an exhaustive search of corporate charter records and current yearly statements filed with the State Department of Taxation and Assessments; and searches of land records in the counties including Baltimore City, where the homes are located. Each source, on its face, reveals its deficiencies. The literature of the homes is self-serving; the list of 10 percent or greater ownership was dated and incomplete; and the corporate charters and yearly statements do not have to yield every stockholder. A family or small group can easily control a home without it being a matter of public record. All the elderly patient or his family can know in this situation is that they are promised treatment, for a fair return, by a corporate entity.

Since the public has such an overriding interest in the prudent consumption of tax dollars, in the health of its aged citizens, and public health in general, it seems imperative that there be mandatory disclosure of all ownership interests. There seems a justifiable right to know who the individuals are who exercise so much control over the lives of our aged.

